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Original Communications.

Gastric Ulcer.

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Gastric or peptic ulcer is usually an acute condition, though it may be chronic. It is an ulcer presenting sharp borders with a tendency to extend in depth. It is generally without collateral inflammation, giving rise usually to one or more characteristic symptoms, as pain, vomiting, haematemesis. Peptic ulcers may be single, but are oftener multiple.

Etiology.—There is no universally accepted view of its pathogenesis; yet there are two points that are generally accepted, viz.: (a) That the ulcer is due to a self-digestion of a circumscribed portion of the stomach; (b) that the alkalinity of the part digested has been previously reduced. Stockton holds that the disease is a neurosis. Traumatic injuries of the mucosa and external traumatism have been suggested as causes.

Predisposing Causes.—Most influential stands, doubtless, hyperacidity of the gastric juice, a condition almost universally present in this disease; although the ulcers may not result primarily from the presence of an excess of acid, it is quite probable that further extension of the ulcerative process may be due to this factor. Some assume the cause of simple ulcer to be gastritis, and it is often met with in the latter disease. The affection is often secondary to chlorosis, anemia, and oftener still, to amenorrhoea. The fact that in all forms of anemia there is a decrease in the alkalinity of the blood is of great inter-

est in this connection. Ulcers occur more frequently in females than in males. It is more common between the ages of seventeen and thirty-five. It is a disease found very seldom in children though Gogart saw an instance in a child thirty hours after birth. We often find this disease present in people who do work which produces strain on the abdomen. The disease is more often found in the poor class.

Pathology.—The shape of the ulcer is usually round or oval. It often happens that there are several ulcers, and these may form large ones, having irregular borders. They are at first superficial, involving only the mucous membrane, though their floor when (seen at autopsy) is below the mucous membrane, owing to a tendency to extend in depth. This characteristic has given rise to the term "perforating ulcer." Thus the ulcer has for its base, very frequently, the muscular or serous coats; but sometimes, and not rarely, the ulcerative process extends through the stomach wall, in which case adhesions form between the stomach and the adjacent viscera, one or the other of the latter organs occupying the base of the ulcer. Almost always the walls slope inward, giving rise to the characteristic funnel shape. The floor of the ulcer is quite generally clean, and rarely may present a hemorrhagic aspect. In size they are quite variable. The majority of ulcers are not larger than a dime, others may measure four inches in their greatest diameter. The position of the ulcer is generally on the posterior wall near the pyloric end, and particularly in the vicinity of the lesser curvature. Of 793 cases collected by Welch from hospital statistics 288 were on the lesser curvature, 234 on the posterior wall, 95 at the pyloric end, 69 on the anterior wall, 50 at the cardiac end, 29 at the fundus and 27 on the greater curvature. Fortunately they occupy the anterior surface, but rarely, this being a dangerous position.

The ulcer often heals by cicatrization. The resulting scar is pale and stellate, and there is puckering of the surrounding mucous membrane. If the ulcer has not extended deeper than the mucous membrane, granulation tissue develops from the edges and the base; this tissue slowly contracts, uniting and leaving a comparatively smooth scar. On the other hand, if the ulcer be large and involve the muscular and serous coats, stricture of the pylorus followed by dilatation may result. Nearly all gastric ulcers would perforate were it not for the development of a localized peritonitis with the establishment of pro-

tective adhesions. The ulcers being usually situated on the posterior wall, the surface of the pancreas form the point of attachment most frequently, though the stomach may also become adherent to the left lobe of the liver, the spleen, omentum, diaphragm or the transverse colon. The organs with which the stomach becomes agglutinated may be penetrated by the ulcerative process resulting in suppurative inflammation; or guided by the limited adhesions, fistulous connections of the stomach with the transverse colon, the pleura, the pericardium, lungs, gall bladder and the duodenum may be established. Osler states there are two instances on record in which the ulcer perforated the left ventricle. Penetration of the ulcer through the posterior gastric wall opens the lesser peritoneal cavity, in which case the base remains limited, producing a condition known as subphrenic pyopneumo-thorax. When the anterior surface of the stomach, which has no anatomic relations with other organs favorable for the establishment of protective adhesions, is perforated general infectious peritonitis rapidly supervenes, if a fatal end be not reached immediately. Intense hyperamia or the erosion of small vessels gives rise to small or moderate hemorrhage. If the ulcer penetrates one of the large vessels, which happens not rarely, then profuse and even fatal haematemesis is the result. This accident is doubtless frequently prevented by the development of a "protective thrombosis." In several instances small aneurysms have been found at the base of the ulcers. (Douglass, Powell and Welch.)

CLINICAL SYMPTOMS.

First they are those of acute gastritis; pain almost immediately after taking food, vomiting the meals in one and a half to two hours streaked with blood. The pain is two to three inches below the ensiform cartilage, of a dull boring character, and is usually localized, and covers an area of about a dollar in size. As soon as the patient vomits the pain is relieved. Sometimes the changing of position of the patient will relieve the pain temporarily. Nervous symptoms are very pronounced after the disease has been running for some time. Vomiting is present in about fifty per cent of the cases, and often the blood vomited is black; this is due to the hydrochloric acid acting on the blood passing into the stomach. This is considered valuable as a diagnostic point, as it shows there is a constant oozing of blood into the stomach.

Physical Signs.—On inspection we find nothing. Palpitation, tenderness is sometimes found, the spot of localized pain being excessively tender on pressure. Percussion, we find a tender spot to the left of the median line, two to three inches from the ensiform cartilage, this is very slight when the ulcer is posterior. Examination of stomach contents shows an excessive amount of hydrochloric acid present.

Complications.—Perforation of the ulcer is a complication. This in nearly all cases leads to general peritonitis, which proves fatal in the majority of cases. Hemorrhage may prove a serious complicating accident, being, in rare instances, an immediate cause of death.

DIAGNOSIS.

Typical cases, in which the characteristic symptoms are present, are easily diagnosed. First we have pain, its peculiar character and coming on immediately after taking food. Hemorrhage and its character in color are almost pathognomonic. Without the presence of hematemesis, for example a positive diagnosis should not be made, and yet this symptom does not appear in fifty per cent of all cases. The presence of hyperacidity, the characteristic pain, the history of case, and the people in whom it occurs, will usually make the diagnosis. In cases where there is absence of hematemesis we may infer the probable existence of ulcer if we have the other characteristic symptoms, such as gastralgia, hyperacidity, localized pain and tenderness, and the dorsal pain point, and particularly if the latter symptom be aggravated by taking food.

Differential Diagnosis.—The principal diseases that we are apt to confuse with ulcer are chronic gastritis, gastralgia, hepatic colic and carcinoma of the stomach. The differential symptoms of carcinoma, ulcer and chronic gastritis are conveniently shown in the following table:

	CARCINOMA.	ULCER.	CHRONIC GASTRITIS.
Average duration.	Six months to one year.	Indefinite.	Long Duration.
Sex	No difference.	Females most.	Males most.
Age	Middle and advanced life.	Mostly young adults.	Mature age.
Tongue.....	Thickly coated.	Dry and red, white streaks in center.	Grayish white, with impressions of the teeth on sides.

Pain	Radiating, often paroxysmal and little affected by food.	Intense, boring pain after food.	Soreness in epigastric region, slight pain, long intermissions.
Indigestion	Marked.	Slight, marked acidity.	Marked.
Hemorrhage	Slight, coffee-ground.	Marked.	Slight.
Secretion	Hcl. absent, increase lactic acid, ferments absent.	Hcl increased, lactic acid decreased, ferments increased.	Arrested.
Vomiting	Varies.	Soon after meal.	Morning.
Tumor	Frequently palpable, painful, and movable.	No tumor, may be thick at pylorus.	No tumor.
Cachexia	Slight Yellow.	None.	Pale, mal-nutrition.
Urine	Dark, neutral or alkaline, indican present.	Amount reduced, Indican present.	Reduced urates, phosphates and total acidity.
Stools	Variable, may pass blood.	Constipation, may pass blood.	Alternating constipation and diarrhoea.
Temperature	Normal or sub-normal.		

Gastralgia.—History of neurasthenia, comes on in middle life, most frequently in females near the menopause. Pain is usually all over the stomach, more frequently when stomach is empty than after meals. Eating usually gives relief. Pressure almost relieves the pain. There is no pain between attacks, no hematemesis, and signs of tumor always absent. General health is less affected than in ulcer, regulation of diet has no effect.

Hepatic Colic.—Pain is constant over region of liver and radiating down right arm. Rapid pulse, profuse perspiration until stone is passed, and jaundice all exist.

PROGNOSIS.

The prognosis is very uncertain, the average mortality being about twenty per cent. The resulting scar may cause persistent gastralgia, and the probability that a cicatrix surrounding the whole or any part of the pylorus may cause obstruction at the orifice, followed by dilatation, must be kept in remembrance. Carcinoma may develop in the floor of an old ulcer.

TREATMENT.

First, we must have absolute rest of the stomach. This is to be accomplished by putting patient in the recumbent posture in bed, and stop all feeding by the mouth for some time, but keeping him well nourished by rectal feeding. All nourishment given by the rectum should be predigested. The process of healing in these cases is very slow, and it is well to impress on your patients in the beginning that they will have to stay in bed for some time, four to six months at least. These patients require a large amount of nourishment and often failure to cure cases is due to improper nourishment. In some cases it is possible to feed your patient both by the mouth and rectum. A very light diet should be used in both instances. The following has been recommended as a diet by the mouth: peptonized milk, egg albumen, scraped beef and a little fine bread. In connection the following may be given by the rectum: at 8 a. m. six ounces of pancreatized milk gruel with one half ounce of bovine and ten drops of tincture of opium, this to be repeated at two p. m. and at eight p. m. Dacosta reports a number of cases that have been cured by a diet of ice cream only.

Medicinal Treatment.—The medicinal treatment has two functions: first, to promote the healing process if possible; second, to do away with the excess of hydrochloric acid, and try to produce an alkaline condition of the stomach. The following are recommended in this connection: sodium bicarbonate and the alkaline mineral waters, as Carlsbad, Kissengen, and Hunyadi. Fleiner's method of giving ten gm. of bismuth in two hundred gm. of warm water on an empty stomach and then allowing patient to drink several swallows of water, afterwards placing him in the horizontal position with hips elevated for about an hour, has given gratifying results. (Anders). About two hundred gm. of bismuth given above manner usually suffices to effect a cure (Sanelieff).

The Relief of Urgent Symptoms.—For the severe pain morphine hypodermatically. Vomiting, cocain, cerium oxalate, bromide of potash and chloral may be administered separately. For the hematemesis rest in bed, large ice bag on stomach and ergot hypodermatically. Perforation calls for surgical measures as soon as diagnosis is made. In

the cases of perforation which have been operated on within the first twelve hours during the past three years 83.78 per cent have been saved (Tinker).

The General Management of Pneumonia Cases With a Study of the Fresh Air Treatment.*

By Kenneth Bradford, M. D.,

Birmingham, Ala.

In considering the management of this all important disease let us first recall the well established truth that we have to deal with an acute infection, of known cause, which runs a self-limited course, tending toward recovery—might I dare add—regardless of therapeutic interference.

This brings us face to face with prophylactic measures, by means of which we can do much toward sparing the susceptible who might be in the line of exposure.

Whether pneumonia is contagious or not, it certainly is infectious, due in the vast majority of cases to the virulent pneumococcus, and where that goes the disease follows provided the soil is fertile. This organism is present in the sputum of those affected and can live in masses of dried secretion for a month when exposed only to diffuse daylight. Direct sunlight kills in an hour or two. As there can be no pneumonia without an organism, and then only in susceptible subjects, and as the sputum is the chief agent for disseminating the pneumococcus, our indications seem clearly established. Thorough disinfection or destruction of the pneumonic sputum; careful and frequent cleansing of the upper air passages, the normal habitat of this and many other pathogenic germs; and protection, as far as possible from exposure to infection, for those generally or locally predisposed.

Returning now to the management of the disease itself, of course, as in all acute and severe infections, the patient should be at rest in bed, in a room well lighted and well aired. I shall come back and dwell more fully on the importance of fresh air in a moment. Careful nursing is very essential, and frequent observations should be made by

*Read before the Jefferson County Medical Society, Feb. 10, 1908.

the physician, for changes may occur rapidly. The aged, young children and alcoholics all need careful watching, and especially is this true of patients who are delirious and might endeavor to escape or otherwise injure themselves. The diet should be liquid, composed as usual of milk, soups, beef juice, soft eggs, well cooked and well strained gruels. Water should not be allowed in large quantities as it might embarrass the circulation.

Let us bear in mind now that we have to battle with a local, pathologic condition, viz., consolidation of air spaces, which we can in no way limit; and a general toxemia, or more correctly, a septicemia, which serum therapy limits in that it possibly prevents complications, but by no means controls. Doesn't this force us to conclude that the only safe and rational treatment is symptomatic, and that it isn't safe to be imbued with one's therapeutic powers? Many cases do well without any medicine. Drugs have their place, but we should be watchful, and use them only as the necessity arises, for all cases do not need them. We should watch the heart and when it shows signs of weakening, then use stimulants; especially is this true at or near the crisis. Alcohol doesn't lessen complications and stimulation isn't always necessary. So its use should be guided by the pulse and the general bodily vigor of the patient.

For excessive and prolonged high temperature, for restlessness and delirium, cool sponging supplemented by the ice cap will suffice. Exceptionally in the robust cold packs may be used. For the cough, pain of pleurisy and the dyspnoea due to it, local applications either hot or cold and codeine seem to be best. Complications must be treated as they arise. As to convalescence, the patient should remain in bed several days after the temperature is normal, especially if there are or have been heart complications. Worry and excitement are to be guarded against, and any undue strain, for sudden death has occurred in this stage due to fright or over-exertion. General hygienic treatment is very valuable here, as it is in cases of delayed resolution, for nothing seems to influence the latter condition directly.

This brings me to the second and a very important part of my subject, "The use of fresh air in the treatment of pneumonia." In no disease is fresh air so necessary for its manifold good effects as in pneumonia. It is a well established fact that warm blooded animals

absorb more oxygen when exposed to fresh air, and what is equally important, eliminate more carbon di-oxide. This of course increases the efficiency of body resistance. Hygiene teaches us that whatever other effects the impurities of expired air may produce, the effect of undue carbon di-oxide in this air is to interfere with respiration. Therefore it must follow that the air we breathe, in order to be free from impurities which we are constantly discharging from the lungs, must be as constantly diluted with fresh *out door* air. This, I may say, is the cardinal principle of ventilation.

If fresh air is necessary for a proper interchange of gases in the healthy lung, of what vast importance it must be to a crippled lung, and every pneumonic patient should have it continually day and night and in large quantities. The good effects are quickly noted and speak for the efficacy of the treatment. The respirations are reduced in number and increased in depth, showing a stimulation and calming of the vascular system; finally the temperature is reduced and much of the delirium and restlessness relieved.

Dr. Thompson of New York, in a recent article on this treatment (*Am. Jour. Med. Sc's.*, Feb., 1908) speaks with the conviction born of a wide experience of the great value of this method, and says it is in general use at the Presbyterian and Bellevue hospitals among all classes of patients and the results have been uniformly good. In hospital practice and else where when it is possible to do so, pneumonia patients should be out of doors, whether the temperature be high or low. Of course they must be amply covered and the heads protected by hoods, hot water bottles furnish heat. Verandahs with roofs and protected by netting may be most servicable. Of course there are many with low temperature reactions who can not stand treatment quite so heroic. This includes the asthenic type, the very old and probably the very young. The principle can be carried out just the same by opening the windows and keeping them open. Artificial heat will keep the room warm enough.

After all it is fresh air these patients need, to stimulate respiration and remove impurities. We may use cold fresh air in some cases, warm fresh air in others, and a combination in some cases, but the cold fresh air is the best in the great majority of cases.

My personal experience of course as yet has been too limited to

draw conclusions of value to you, but the results have convinced me of the absolute indication for this simple and cheap aid in the symptomatic treatment of pneumonia.

The Circulation of the Tractus Intestinalis.

By Byron Robinson,

Chicago, Ill.

We call attention to some of the important vascular landmarks of the tractus intestinalis in the accompanying illustration, viz.:

1. *Appendicular Circulation.*—In this subject (number 36) the appendix was supplied by two small arteries. If meso-appendicitis arises which generally occurs in 50 per cent of adult subjects it may compromise the minimum blood supply of the appendix through meso-appendicitis and end in appendicular disease. I found that 75 per cent of the blood supply only could be injected in the appendicular artery as its lumen was occasionally contracted, compromised by cicatricial peritoneal adhesions. The appendix is the weakest segment of the tractus intestinalis and is consequently subject to clinical disasters.

2. *Arches of the Ileo-Colic Artery.*—In the region of the junction of the ileum and colon there are numerous, strong arches, compact vascular anastomoses. They average 5 in each subject. They are in my opinion remnant, the rests of a maximum circulation for a vast herbivorous stomach—at present the fading appendix. This is one of the best examples of vascular rests from a fading viscus appendix.

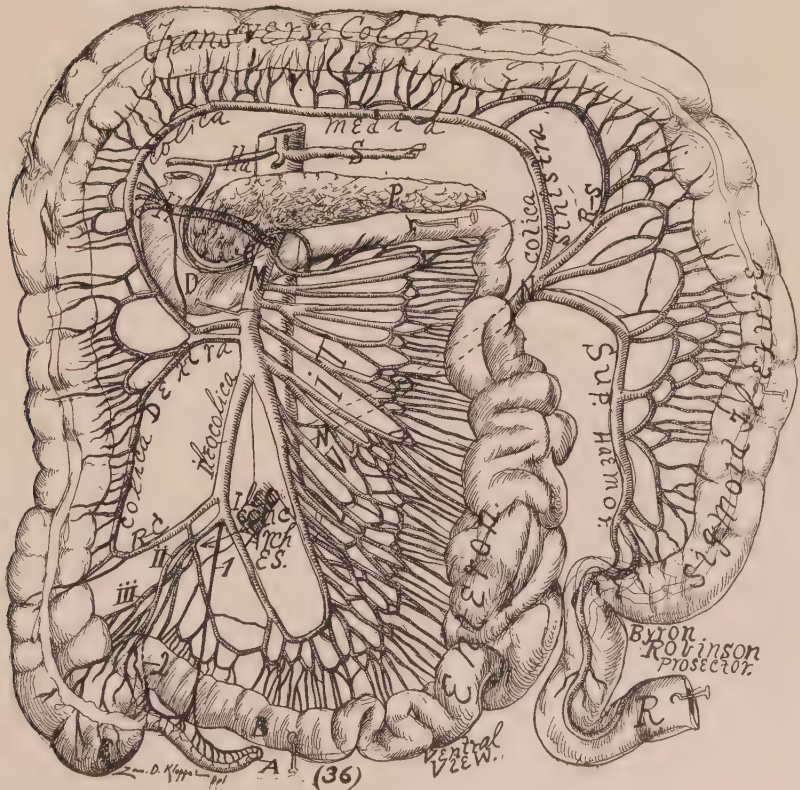
3. *Vasa Intestina Tenuis.*—These numerous vessels supply the small intestines, the enteron—the business or functioning portion of the intestinal tract. They vary from 12 to 24 in number and conduct an enormous volume of blood when the enteron is digesting the passing food.

4. *The Sigmoid Vascular Supply.*—This blood supply is important because the sigmoid is subject to disease in 80 per cent of adults. The trauma of the psoas muscle produces sigmoiditis and mesosigmoiditis in over 80 per cent of adults, hence, its blood supply is important.

The sigmoid receives a powerful blood supply from the arteria mesen-

terica distal (inferior). Though, it is remarkably subject to disease, yet the sigmoid blood supply is so powerful that it nourishes the sigmoid under difficulty (mesosigmoiditis). Clinical disasters do not arise frequently in the sigmoid because it possesses ample blood supply and drainage. The vasa intestina tenuis consist of three segments, viz.: (a) trunk; (b) arches; (c) straight terminal arteries.

(5) *Arteries Intestinales Terminales Recta*.—The straight terminal arteries of the intestines are of significant importance in practice. They consist of numerous abundant, parallel, extended arteries which extend from the arches to the intestinal wall. The chief signification of these arteries are in the surgical practice of ligation. In resecting segments of the intestine the ligatures to be placed closely adjacent to the intestinal wall so that arches may not be occluded. This suggestion applies to the colon as well as to the enteron. The straight terminal arteries of the intestines are of ample length (one-half to two inches) to ligate without molesting the arches.



ARTERIES OF THE COLON AND ENTERON.

Fig. (36). I injected this specimen with red lead and starch and dissected it under alcohol. It is drawn as correctly as possible by the artist, Zan D. Kloppe. The remarkable factor in it is that there are two hepatic arteries; one from the proximal (Ha.) arises from the coeliac and the other distal (H) arises from the arteria mesenterica! proximal (superior). There are six ileo-colic arches. The colica media is duplicate and unites adjacent to its use to the colica dextra. The appendicular artery consists of one main artery (1) and an accessory (2). Observe the arch(intestinal) between 1 and 2 presenting the idea that the appendix was once a part and parcel of the intestinal tract and supplied by blood vessels similar to that in form of the colon and enteron. Note the powerful and numerous vascular arches of the sigmoid.

**Laminectomy for Fracture of Tenth Dorsal Vertebra.
Recovery.**

J. M. Mason, M. D.,

Member of the Medical Association of the State of Alabama.

Certain injuries of the spinal cord attended by paralytic symptoms are amenable to surgical treatment, and prompt intervention will result in improvement or cure.

Those injuries in which the outlook is most hopeful are the paralyses due to compression of the cord by blood depressed bone, or foreign bodies; those in which the prognosis is least favorable are the ones due to contusion and destruction of the cord.

This last class, with complete transverse division of the cord, most authorities consider beyond the hope of repair with or without the aid of surgery. Still, decidedly opposing views are held by surgeons of prominence as to what may be accomplished by operation in such cases, and as the matter cannot be considered settled, I will present the conservative views recently expressed by Prof. John B. Murphy on the one hand, and the more radical position of Drs. Harte and Stewart on the other.

Murphy has made an exhaustive review of the subject in an article entitled "Surgery of the Spinal Cord," which appeared in The Journal

of the American Medical Association, March 2, 1907, and which was published also in *Surgery, Gynecology and Obstetrics*, April, 1907.

Such expressions as are attributed to him in my paper are quotations from the above article.

Harte and Stewart published in *Transactions of the American Surgical Association*, 1902, vol. 20, the report of a case of severed spinal cord in which myelorrhaphy was followed by partial return of function. This report also appeared in the *Philadelphia Medical Journal*, June 7, 1902.

Such expressions as are attributed to them are from the above report.

Murphy says "The divided axons of the cord do not regenerate as they have no neurilemma, and suture of the divided segments is not only useless, but adds to the danger present." "In fracture with division of the true cord (that is above the cauda equina) operation with suture of the cord is absolutely worthless; functional regeneration of the columns of gray matter never takes place."

"When fracture takes place below the twelfth dorsal vertebra, the treatment and prognosis are entirely altered. The cauda equina is made up of essentially peripheral nerve fasciculi and not of spinal cord fasciculi. Both motor and sensory neurons in the cauda, outside the cord, are histologically capable of regeneration under favorable conditions, that is, after accurate suture and exact approximation of the divided caudal fasciculi under aseptic conditions."

Stewart and Harte in the report of their case, quote much experimental work which would tend to prove the possibility of cord regeneration.

They say: "It is unrefuted that several peripheral nerves may functionate after the ends have been approximated, but that regeneration of the central nervous system occurs is denied by practically all writers and investigators; and most of those who do not deny simply question. The reasons for this non-regeneration are not clear. Some theorize that it is due to the absence of the white substance of Schwann, through the agency of whose neuclei regeneration is accomplished, while others hold that the axis cylinders are secreted by the neurilemma cells which are present in the cord; it has been asserted that the new nerve fibres are built by the connective tissue cells; and it has been claimed that they are formed by the colorless blood corpuscles. Fickler believes that, if the normal circulation of blood and lymph is re-

stored, the axis cylinders may grow. If we accept the theory of the "central school," to which the overwhelming majority of observers belong, and who teach that regeneration occurs by the outgrowth of the old axones of the central stump of a divided nerve, there is no apparent obstacle to the regeneration of the fibres composing the spinal cord."

"Voit, Muller, Dentan, Strobe and other workers have demonstrated in animals the partial regeneration of portions of the central nervous system as well as of divided peripheral nerves."

Stewart and Harte very properly remark "From the standpoint of workers among human beings one positive clinical case neutralizes many negative neuropathological investigations and cancels innumerable physiological experiments on animals."

A very brief review of their case is as follows:

Patient, a white female, aged 26, was shot at the right of the 7th dorsal spine, the bullet passing directly into the spinal canal. There was immediate and complete loss of sensation and motion below this point. The patient was subjected to operation 3 hours after the accident. The laminae of the seventh and eighth dorsal vertebrae were resected. After removing the bullet, fragments of bone, and lacerated nervous tissue, the distance between the segments of the cord was 3-4 of an inch. This statement was verified by the assistants, Drs. Mitchell, Van Meter, Fraley, and Newlin. The ends of the cord were approximated with chromic catgut sutures. The dura could not be approximated. The wound was drained.

Without going into the numerous details of the post operative improvement, the notes at the sixteenth month say "general health excellent; voluntarily flexes toes, flexes and extends legs and thighs and rotates thighs. While sitting, leg can be raised from the floor.

Patient slides out of bed unaided, and can stand with one hand on a chair. Function of bowels and bladder are under complete control. She has sense of touch, position pain and temperature all over, &c. &c."

This remarkable restoration of function must convince anyone that some regeneration of the destroyed spinal cord can take place.

Murphy says "The immediate complete bilateral paralysis of both motion and sensation is the only positive evidence of division of the cord." If we follow his teaching in the surgical treatment, the first thing in any case of spinal injury should be to establish the presence or

absence of this group of symptoms and upon finding them, to desist from operation. If we incline to the views of Stewart and Harte, we are justified in enlarging our operative scope to include this class of cases.

Murphy further states "where there is evidence of compression by blood or small fragments with fracture or dislocation as shown by the fact that the paralysis is not immediate, not circular and not complete of both motion and sensation, an immediate operation may be indicated." He believes that operation is contra-indicated in gun shot wounds, stab wounds and other similar injuries where the cord is even partially divided, except for the removal of blood, depressed bone or bullet.

Contusion of the cord will often be followed by progressive degeneration, so operation in such conditions does not offer as good prognosis as the case of pressure paralysis.

In the Birmingham district spinal injuries are of frequent occurrence, particularly as the result of mine accidents. Many of the cases are at once fatal, owing to complicating injuries, but a number come to operation. There is generally fracture-dislocation of the spine with extensive cord injury. So far as I have been able to observe these cases, the results have been rather unfavorable.

My own case did not occur in the mines, but resulted from a fall from an electric light pole.

The symptoms in this case did not indicate that the cord was completely destroyed, as the paralysis, while immediate, bilateral and circular was complete only as to motion. Sensation was very much impaired but not entirely abolished.

This patient was presented to the Jefferson County Medical Society at the regular clinical meeting held in March, 1907.

The history of the case is as follows:

J. O., colored, male, lineman, fell from the top of a telegraph pole about 4 p. m., July 12, 1905, and was brought to St. Vincent's Hospital an hour later. I examined him immediately and found the following conditions:

There was extensive contusion over the dorsolumbar region of the back, and complete motor paralysis from the waist down. Sensation was very much impaired but was not entirely abolished. Tickling the sole of the foot would cause reflex movement of the big toe, but this movement could not be voluntarily made.

No distinct irregularity in outline of the vertebrae could be made out and crepitus could not be detected.

He was sent to the ward for a few hours' observation. During the night he voided urine once, after which the catheter had to be used.

A diagnosis of the compression of the cord, probably due to fracture was made. From the reflex movements of the toes, the incompleteness of the sensory paralysis, and the fact that urine had been voided once, it appeared that the injury to the cord had not entirely destroyed it. On account of the ability to urinate once and the abolishment of that function afterwards, it was thought also that there was some progressive pressure from hemorrhage.

Altogether the case seemed favorable for operation and this was undertaken on the afternoon of July 13, about 22 hours after the infliction of the injury.

The tenth dorsal vertebra was found to be broken and driven downward upon the cord. Upon removing the laminae it was found that the line of fracture passed through the pedicles, and the loose fragments were removed. The cord was pressed upon by the depressed bone, and was surrounded by an extensive clot. The clot was extradural. The dura was slightly lacerated but no blood was observed beneath it. Free venous hemorrhage apparently from the surface of the broken vertebra persisted for a while but was finally controlled.

A drain was passed down to the dura and the rest of the wound was closed with silk worm gut.

The following post operative notes were made:

July 16th, third day after operation, bladder acts naturally; July 23, tenth day, bowels act without enema, motion returning in toes and ankles. July 28, fifteenth day, moves feet and legs to the knee.

August 20, thirty-eighth day, is up in rolling chair, movements of legs more extensive and stronger. Sept. 2, fifty-first day, can sit up in chair and move legs and thighs. Legs are weak, but back is strong, and he can sit up for a long time without tiring. Sept. 18, left the hospital.

Gradually he became able to get from his bed to a chair, then from the chair on crutches, then to a walking stick, and about Dec. 1 was able to walk a short distance without his stick.

Finally, about the 15th of June, 1906, eleven months after the in-

jury he returned to work, and is now engaged in light work with a construction crew. He says he feels entirely able to get back to his regular work as a lineman, but does not want to risk climbing poles as he would have to do.

Some infection occurred in the wound in the back from soiling with excretions, and, about the end of the second week, ulcers appeared on each heel. About six months after the injury a small sinus appeared in the scar, and upon curetting it a buried silk worm gut suture was removed and the sinus promptly closed.

Except for some neuralgic pains in his left leg, the patient is now as well as he ever was.

In any case where the symptoms indicate that the injury to the cord is anything less than transverse division, I believe that operation is indicated.

Nothing could be worse than the condition of those patients who have sustained entire destruction of the cord and who have not been subjected to operation, so I would be inclined to give them the slight chance of improvement which operation might hold out.

In any event, early operation is to be practiced, and delay should not be allowed to add to the chances against the recovery of the patient.

A "Plea for Conservatism in the Treatment of Tubercular Knee."

*By Wm. Thompson Berry, M. D.,
Birmingham, Ala.*

Associate Professor Anatomy and Professor Orthopedic Surgery in
the Birmingham Medical College.

Because of the fact that amputation of the leg above the knee is so common a practice by many of the surgeons for a tubercular knee I have purposely brought a case to your attention tonight which has been treated along conservative lines with good result. This case is one of 5 or 6 which I have treated within the past few months with similar results.

Case 1. Female, age 7 years, white, in good health. She had been complaining of pain in her knee-joint and limping for several weeks before I saw her. Passive motion ranged between 20° and 170° of flex-

ion. Attempts at full extension caused reflex resistance and twitching of the muscles of the thigh. Measurement showed an increase of 3-8th of inch at the knee, a decrease of 3-8th of inch at the calf and a decrease of 5-8th of inch 4 inches above the patella. Treatment was begun on June 7, 1907, by putting the patient to bed and with weight and pulley for several weeks, the slight deformity was overcome and a plaster-of-paris cast was applied from the perineum to, and including, the foot. This cast was removed at interval of every 3 to 4 weeks, examination made of the limb, and plaster cast re-applied. This line of treatment was kept up for several months (5 to 6) and then a Thomas knee brace substituted for the cast and patient allowed to walk and play. The length of time the brace should be worn depends upon the condition of the case, no fixed rule can be laid down for every patient.

Flexion of the knee is the chief evil to overcome in this affection. It attracts attention early, and it requires persistent restraint all during the treatment of this disease. The limp, slight increase at knee and decrease above and below knee, impairment of passive motion, reflex-muscular action, an uneventful previous history and absence of any special subjective symptoms are among the very first indications of tuberculosis of the "knee-joint."

It is not easy always to wait for natural repair and recovery in joint troubles of this nature, but nevertheless the best results are not achieved by radical surgery in tubercular joints of the young. The conservative plan of treatment encourages a reliance on nature which gives full assurance of timely intervention by nature's own reparative processes.

All the joints and functions are to be retained rather than surrendered in the young, but this consideration is less important in the treatment of adults who may rightly desire and expect a speedy recovery.

Normal motion is nearly always out of the question, but to get the best possible termination of the disease it is evident that the destructive process must be stopped as quickly as possible. This can best be done by an arrest of function which is the only effective resort. If we recognize with what we are dealing sufficiently early this protection can be carried out to a certain extent in every case of "knee-joint tuberculosis,"

By good fixation we may expect ankylosis to be lessened by our moderating the inflammation and abating the quantity and density of its obstructive products. It is a false belief some doctors have that fixation of a healthy joint for an indefinite time will produce "ankylosis." It can be creditably stated that such will not be the case. Therefore let fixation be applied just as soon as possible, with care and uncompromising persistence with the knowledge that so far as the joint is healthy no harm can come, but it may secure ability and symmetry for the rest of the patient's life. In postponing the treatment you open the door for permanent disability and deformity.

Some Remarks on the Intra-Muscular Injection of Mercury.*

*By A. F. Toole, M. D.,
Birmingham, Ala.*

If time permitted, I should feel it due to you as a society, to present a more extended paper, collecting the scattered opinions of various authorities upon this method of treatment; for such opinions have been considerably modified during the past few years, and present ideas well worthy of consideration. Instead of so doing, however, I shall merely try to give some conclusions, unbiased, I trust, arrived at after a rather limited personal observation.

As a preface, I beg to recall briefly a few old therapeutic truths, both general and as applied to the treatment of syphilis.

1. The dosage of any drug having a specific action on an infection, should be the maximum one compatible with health.

2. This constant maximum applies to its absorption and consequent action upon the tissues of the entire body, and not to its mere administration.

3. Any drug regularly administered throughout a long period is apt either to irritate the part to which it is applied, or to cause the part to become less receptive.

4. The stomach, as a depository for drugs intended for the general circulation, has but one point to recommend it—convenience.

5. Treatment of an infection (e. g., syphilis) by a drug, demands

*Read before Talladega Co, Med. Society, Jan. 14, 1908.

that the drug reach the infection regularly; for the infecting organism may regain lost ground through even slight remission. This demands regularity and unremitting effort on the part of the doctor or patient, and this would demand of the patient characteristics which the frailties of human nature do not allow.

As to the treatment of syphilis; its sum and substance is of course to give the maximum amount of mercury with the minimum of ill-effect; in fact, the maximum amount is determined largely *by* the ill-effects.

Take two patients with malaria; let one chew up cinchona bark and the other take quinine in some form; when one reached the maximum amount of cinchona bark allowed by palate and digestion, his blood would contain perhaps not one-fourth of the active curative principle being received by the one who reached the maximum of quinine. But note right here, and apply the parallel later, that the cinchona bark may stop the chills for a while, without killing all the organisms.

This, to my mind, is the most really important factor in determining the superiority of methods. Such items as pain, inconvenience, occasional untoward effects, and necessity of administration by the doctor, are subsidiary to the question of maximum dosage, even did they assume the proportions formerly attributed to them by some writers.

I need hardly go over in detail the advantages and disadvantages, so often tabulated, of the more ordinary methods of administration—by mouth, by inunction, and by hypodermic medication. Perhaps every enthusiast somewhat exaggerates the disadvantages of the methods he does not favor; and lest I be classed as a mere enthusiast, I will pass by all objections to the administration by mouth, except the one which is fatal to ideal treatment—uncertainty of absorption. Let a patient take three protoiodide pills today; no one knows how much of their contents reaches the tissues of the body and the syphilitic infection. Worse than that, let the same patient take three pills tomorrow, and no one can tell whether he will absorb one-half as much or twice as much as today. The only thing certain about it is, that after three months of this method, his stomach will be absorbing less than today, even in the remarkable event of his swallowing as many pills. Another fact; mercury is a characteristic irritant; when absorbed, it is excreted largely through the stomach and intestines. An irritant, then, when given, it is the same irritant when excreted; no wonder salivation and diar-

rhoea can result from half the dose given by other methods. I will rest the case against mouth administration as a superior method, and withhold reference to its irksomeness, its irregularity, and its inconvenience.

You will note that the inunction method escapes such charges. In itself, it is a most efficient and valuable way of administration; if a patient *could* and *would* apply this method, I would not endeavor to supplant it by injections; I believe the issue between the two to be a matter of convenience, almost wholly; or, a matter of "could and would," which limits it in the average patient to a Hot Springs sojourn.

Coming at last however to actual results with hypodermic administration, I will try to drop general argument. The more serious charges brought against this method have been pain, abscess, and pulmonary embolism.

Pain there is, in a most varying degree. The first injection is almost always followed by some pain, rarely sharp or severe, for perhaps several hours. It is a rule, however, which I have so far not seen broken, that the second is less painful, and from the third or fourth on, the pain is either absent or so slight as to cause no reluctance in the mind of the patient.

An abscess, if one occurs, is simply a reproach to the operator for his lack of asepsis, just as it would be in case of a clean operation. I have never seen one, and if I should get one would take the blame myself, and attribute the fault to the injection *per se*. By "abscess" I do not, of course, include the occasional "induration" which follows in a certain percentage of cases.

Pulmonary embolism is an accident quite possible, but only in neglect of a most important precaution; namely, making certain before injection that the point of the needle is not in or close to a puncture of a blood-vessel. In private practice I have so far escaped this disagreeable happening, although I saw it twice during a few hundred more hurriedly-given injections in a large dispensary. Even should it occur, its effects are slight and temporary, except in a very few recorded cases.

As to efficacy of treatment. Cases may be considered in two classes: (1) Ordinary cases, amenable to whatever form of treatment is *thorough*; (2) stubborn or intractable cases.

Cases of the first class may be cured by any *thorough* treatment; that is, by treatment which obtains the constant maximum dosage for the necessary time, said time having been rather empirically set at about two years. Intra-muscular administration is here the superior method insofar as, for reasons stated, it secures such constant maximum dosage; in certain cases of even mild type, such result cannot be attained through internal administration. In employing it, I have watched a case from the initial sore; have seen a beautifully typical rash develop in the sixth week; have allowed it four days of progressive increase, and have then started injections. In one case of this type, the rash began to fade in 48 hours, and had absolutely disappeared in 5 days. This patient would seem to any examiner entirely free from disease, and would not take up by choice any other line of treatment.

But it is in cases of the second class that injections have won more general credit; and so far perhaps the majority of practitioners have used them merely as an emergency measure, so to speak, in patients where sufficient mercurialization was impossible by other means. Lesions of the late secondary or of the tertiary stage, such as headache, gumma, iritis, and syphilitic toxaemia, have resisted ordinary modification only to respond with decided success to injections, plus of course the iodides when indicated.

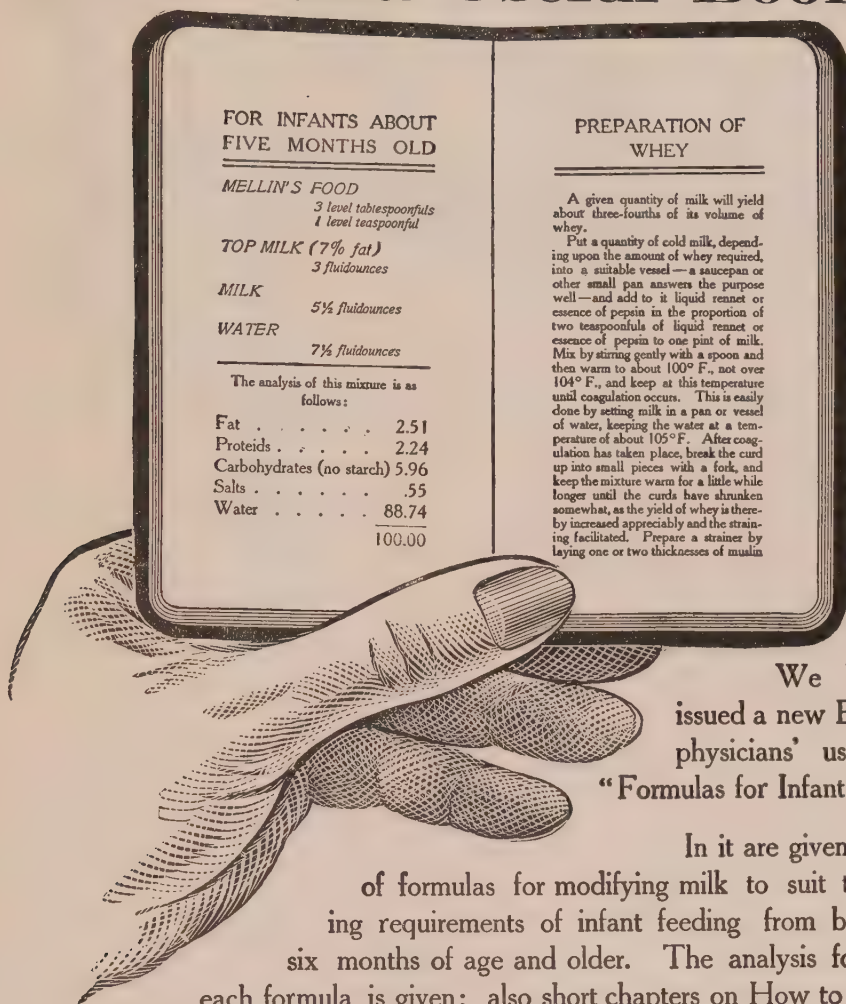
Very briefly as to technique. One may use either a soluble or an insoluble salt of mercury; the controversy as to the better form is still on. If the soluble, perhaps best is a 1 per cent solution of the bichloride in 6 per cent solution; dosage, 10 to 15 minims every two or three days. If the insoluble, we may take the salicylate suspended in benzoin. 1 to 10; dosage, about 15 minims once a week. This is difficult to prepare correctly, except after careful instructions as to detail. The site of the injection is about an inch and a half below and away from the upper end of the gluteal fold; thence directly into the mass of gluteal muscles. The syringe must be detached, and the needle watched for a minute to see if bleeding occurs. The needle must be specially adapted in calibre and length, with a suitable syringe.

Summing up, then, I would advocate this method as the best so far known in *any* case from the standpoint of convenience and regularity of dosage; and as the distinctly superior treatment in persistent or dangerous lesions, from the standpoint of that one essential, maximum dosage of a specific drug.

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Put a quantity of cold milk, depending upon the amount of whey required, into a suitable vessel—a saucepan or other small pan answers the purpose well—and add to it liquid rennet or essence of pepsin in the proportion of two teaspoonfuls of liquid rennet or essence of pepsin to one pint of milk. Mix by stirring gently with a spoon and then warm to about 100° F., not over 104° F., and keep at this temperature until coagulation occurs. This is easily done by setting milk in a pan or vessel of water, keeping the water at a temperature of about 105° F. After coagulation has taken place, break the curd up into small pieces with a fork, and keep the mixture warm for a little while longer until the curds have shrunk somewhat, as the yield of whey is thereby increased appreciably and the straining facilitated. Prepare a strainer by laying one or two thicknesses of muslin

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Chemist and Graduate of the "Ecole Centrale des Arts et Manufactures de Paris" (France)
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DEAN'S OFFICE

I.V. STANLEY STANISLAUS, Ph. g., B. Sc. Phar. D., Dean
Philadelphia, Pa., March 28th, 1907.

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	99.50
Loss.....	.50

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I. V. S. STANISLAUS, Analyst.

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Editorial.

W. H. BELL, M. D., Editor.



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The Program for 1908 and a Permanent Home for the Jefferson County Medical Society.

We gladly give space in this issue for the program for 1908 for the Jefferson County Medical Society, continuing the plan adopted in 1907 of having weekly meetings and a printed program prepared for the year. A committee composed of Dr. Lewis Whaley, Dr. J. M. Mason, Dr. W. P. McAdory, Dr. Cabot Lull and Dr. Ross Snyder was appointed to arrange this program. This committee has done its work well, and a most interesting and profitable year is promised the members of this society. The success of the year is assured if every member on the program will exert himself to give due time for preparation and be on hand when his time to read his paper arrives. If we may be allowed to do so, we would suggest that each one have his paper in manuscript, so that the idea of having the year's work published in a volume of transactions may be carried out. We believe the idea to be a practicable one, and hope before the year is out to see plans made for

accomplishing this. The program before us well and fully carried out would make a volume of which any society might be proud. We hope to give our readers the benefit of a large number of the papers in the Journal, yet we think it would be well to have them published in a volume of transactions also.

The society a few months ago also started a movement that we hope may be pushed until its object is attained; that is to secure a permanent home for the society. A committee was appointed to investigate, and devise ways and means for this. This movement was started, however, just before the coming of the financial panic that struck us last fall, and on this account but little progress has been made. With the passing of the panic and the coming on of prosperous times we hope the matter will soon be taken up again, and plans made for the securing of a permanent and desirable home.

In our last issue we published a letter from Dr. Geo. S. Brown on this subject, in which he advocated the raising of the dues of the members to ten dollars a year. He suggested the leasing for a few years of a hall in one of the office buildings of the city (if possible), with part of the funds thus secured, and placing the balance in a sinking fund to be used with other funds that may be raised in the purchase of a lot and the erection of a building. Whether this is the best plan to adopt we are not prepared to say, but we do urge the need of a better place of meeting than the one now being used, and believe a plan to get a better one and a permanent one can be devised.

As the Library Association is made up entirely of members of the Jefferson County Society, we think the plan of merging the two into one, as suggested by Dr. Brown, a good one. Beyond a doubt, the advantages of the library and the comfortable quarters will compensate for any increase in the dues that may be necessary to secure them.

The Old Doctor.

The old physician is usually the "doctor of the old school." That does not mean that he employs so much the old methods and clings to the old treatments, for such physicians lose their practice and are forced to other labors to earn their bread. But the old physician who keeps in touch with the movements in his profession and with the needs of human nature learns the secrets of the human soul. The young man

depends usually upon his skill and his knowledge of the human body, while the old man has learned the way to the body through the mind and spirit of which he is master. A friendly visit from the rich-souled old physician, who knows this world and has helpful hopes for the next, is worth more usually than the best prescriptions of the latest investigations of human diseases. Men's bodies suffer frequently when only their souls are sick. There is a healing in the hand of the doctor of the old school. The old, much-bent, shawl-covered, tottering physician who drove about a Southern city, accompanied by his aged wife, was a benediction in every sick room which he entered, and his word of counsel was a heavenly blessing to his own skillful son and to the younger men who were in full powers of their professional life. The old man's diagnoses and the old man's prescriptions may be worth no more than those of the younger men, nor even as much; but the old man's ripe, mellow life has in it the power of healing. Age is the world's best medicine, for it reaches the souls of men. The lesson for the man of small years who would serve his contemporaries may be learned from him who has found the soul of humanity.

The above from a non-medical contemporary reminds us of the great tendency of some of the younger doctors to discount the experience and wisdom of the old "Nestors" of our profession. They seem to think that the old men should be placed "on the shelf," and give place to the young men who have recently had the best training in the best colleges and hospitals of the land.

We recognize the advantages that the young men of today have in the study of medicine over those of fifty and sixty years ago. But do those fifty and sixty years of experience in studying the "needs of human nature and the secrets of the human soul" count for naught? Of course reference is made to those old men who have never ceased to learn, those who have been progressive, and aggressive, and have kept up with the advances that have been made; indeed, have been those who have made progress, advances and history, and have made it possible for the young men of today to be able to reap advantages that they did not have in their younger days. Let our young men honor and respect these old men, our fathers in the profession, and avail themselves of every opportunity to learn from their rich mines of experience.

Anent Those Resolutions.

In presenting to the Jefferson County Medical Society the resolutions concerning the violation of our code of ethics by certain members of the society who comprise the staff of one of the leading hospitals of this city, it was far from our intention to arouse prejudice or strife. Our sole desire was to correct what we conceived to be a growing evil, and we thought all that would be necessary would be the calling of the attention of the society to this evil to bring about its correction. We have found, however, such not to be the case. We still believe that if the question had been allowed to come to a vote on its merits it would have unquestionably carried. The muddying of the waters by mixing the question under consideration with the contract practice, the fear of some members of the staff and others to speak and vote their convictions, the lateness of the hour, and the unfair advantage taken in the motion to table, all contributed to the tabling of the resolutions.

However, the question is not settled. We do not believe the majority of the members of the Jefferson County Society think it right and ethical for members of the staff of this nor any other hospital to be required to do gratuitous practice for people or organizations who are able to pay for such practice. Nor do they believe it right for all ward patients sent to this hospital to be taken from the attending physician and turned over to the staff physician, who cannot collect a fee for it. These and other questions of justice and right will not be downed until justice and right prevail. We believe the profession of this county and city is too honorable and independent to be dictated to always as to their ethical conduct by any hospital management.

To Our Subscribers.

We have recently sent the annual statements to our subscribers. Many of these have promptly responded. To them we express our thanks. To those who have as yet neglected the matter we desire to say that we will appreciate a prompt remittance of the small amount due. While the amount is small to each subscriber, and for this reason he is liable to overlook or forget it, yet in the aggregate the amount to us is an item, and we find it necessary to have some money to run even a medical journal. Some seem to think differently, but we can assure them this is not correct. Some even condemn a journal for the charac-

ter of its advertisements, and then forget entirely to pay the small amount of their subscription until it is more than a year behind, and when reminded of it by a statement say "please discontinue." Of course there are only a few of this kind—a very few on our lists, and their number grow instantly smaller the moment we find out who they are. We appreciate the support and patronage of the doctors of Alabama, and will continue to do our best to merit it. To aid us in this don't forget the small amount of your subscription if it is due.

Personal Notes.

Dr. A. A. Walker, of this city, will leave the last of February for a year's stay in the medical centers of Europe, which he will spend in study.

Announcement has been made of the marriage of Dr. C. E. Dowman, Jr., of this city, to Miss Carolina Westmoreland of Atlanta, Ga., to take place on March 25th.

Dr. J. J. Odom, of Ensley, suffered injuries from a fall on his head as a result of a run-away accident on the 10th inst. We are glad to learn that they are not serious, however.

Among the recent medical men visiting Birmingham, were Dr. W. C. Head, of Johns; Dr. Elgin, of Brookwood; Dr. L. A. Jenkins, of Cardiff; Dr. L. C. Neil, of Adger; Dr. E. G. Givhan, of Montevallo, and Dr. T. J. Bickley, of Calera.

Dr. J. U. Ray, of Woodstock, was in the city on the 1st inst. Dr. Ray is Secretary and Treasurer of the Association of the Surgeons of the Southern Railway. This association will hold its next meeting in Birmingham on April 28th to 30th. An interesting program is being arranged, and a good attendance is expected. The other officers of the association are: Dr. H. T. A. Lemon, Washington, D. C., President; Dr. C. H. Starkel, Bellville, Ill., First Vice-president; and Dr. T. J. Happel, Trenton, Tenn., Second Vice-president.

Program of the Jefferson County Medical Association for 1908.

MONDAY, FEBRUARY 3.

Clinical Meeting and Voluntary Papers.

MONDAY, FEBRUARY 10.

Lobar Pneumonia.

Etiological Factors, Epidemicity and Diagnosis.....Dr. E. S. Casey

Specifics—Their Actual & Comparative Values..Dr. R. M. Cunningham

General Management of Cases With a Study of the Fresh

Air Treatment Dr. Kenneth Bradford

Physical Signs of Lobar and Broncho Pneumonia in

Children Dr. J. D. Heacock

MONDAY, FEBRUARY 17.

Diseases of the Rectum.

Etiology & Pathology of Polypi, Ulcers & Cancers...Dr. C. E. Dowman

Treatment of Polypi, Ulcers and Cancers.....Dr. G. A. Hogan

Pathology, Diagnosis & Treatment of Hemorrhoids..Dr. E. M. Robinson

MONDAY, FEBRUARY 24.

Etiology, Pathology and Treatment of Adenoids and Dis-

eased Tonsils Dr. B. D. Sibley

Syphilitic Lesions of Mouth, Nose and Throat.....Dr. L. G. Woodson

Hereditary Syphilis Dr. W. R. Callen

Causes & Treatment of Vulvo Vaginitis in Children..Dr. W. W. Ransom

MONDAY, MARCH 2.

*Needed Improvements in the Organization of the Medical Association
of the State of Alabama.*

Discussion opened by Drs. E. P. Riggs, W. M. Jordan, Cunningham
Wilson and G. S. Brown.

MONDAY, MARCH 9.

Treatment of Injuries of the Bladder and Ureter. (Traumatic

or Accidentally Inflicted During Operation)..Dr. J. D. S. Davis

Common Functional Disorders of the Urinary Tract...Dr. Harry Levy

Diagnosis of Vesical Calculus Dr. J. H. Edmonson

MONDAY, MARCH 16.

The Care of the Pregnant Woman.....Dr. F. A. Lupton

The Management of Normal Labor.....Dr. J. H. Edwards

- The Management of Normal Puerperium.....Dr. R. H. Hamrick
Caesarean Section at Full Term Versus Premature Delivery
when Normal Labor is Impossible.....Dr. L. C. Morris

MONDAY, MARCH 23.

Tuberculosis.

- Acute Miliary Tuberculosis.....Dr. J. S. Winters
Phthisis, Diagnosis and Prognosis.....Dr. J. G. Staples
Home Care and Feeding of Phthisical Patients.....Dr. G. W. Brown
State and Municipal Control of Tuberculosis.....Dr. R. B. Harkness

MONDAY, MARCH 30.

- Diagnosis and Treatment of Perforating Gastric
Ulcer.....Dr. Gaston Torrance
The Administration of Ether by the Rectum.....Dr. W. T. Berry
Removal of Foreign Bodies from the Larynx, Trachea and Bronchi.
(a) Tracheotomy.....Dr. D. F. Talley
(b) Bronchoscope Dr. S. L. Ledbetter

MONDAY, APRIL 6.

Clinical Meeting.

Election and Instruction of Delegates to the State Association.

MONDAY, APRIL 13.

- The Feeding of Healthy Infants and Children.....Dr. W. W. Long
The Feeding of Delicate & Sick Infants & Children....Dr. T. D. Parke
Hookworms Dr. R. T. Comer

MONDAY, APRIL 20.

- Multiple Neuritis, Diagnosis and Treatment Dr. B. L. Wyman
Tabes Dorsalis, Diagnosis and Treatment—with Consider-
ation of some newer methods, Re-education,
etc.....Dr. F. E. Nabers
Neurasthenia Dr. C. M. Nice

MONDAY, APRIL 27.

The Diseased Prostate.

- Some Points in Diagnosis Dr. A. F. Toole
Treatment of Chronic Prostatitis Dr. C. W. Shropshire
Sequelae of Prostatitis Dr. J. E. Dedman

MONDAY, MAY 4.

Clinical Meeting and Voluntary Papers.

MONDAY, MAY 11.

Address Dr. Michael Hoke, Atlanta, Ga

MONDAY, MAY 18.

The Diarrhoeas and Digestive Disturbances of Children in Summer.

Classification and Etiology Dr. J. Ross Snyder

Pathology Dr. W. R. Ward

Symptomatology and Natural History Dr. R. V. Mobley

Prophylaxis and Treatment Dr. Hardee Johnston

MONDAY, MAY 25.

Hernias.

Etiology, Diagnosis & Treatment of Internal Hernia...Dr. D. F. Talley

Diagnosis and Treatment of Strangulated Ventral and

Femoral Hernia Dr. W. P. McAdory

Diagnosis and Treatment of Strangulated Inguinal

Hernia Dr. Mack Rogers

MONDAY, JUNE 1.

Clinical Meeting and Voluntary Papers.

MONDAY, JUNE 8.

Mining Camps and Manufacturing Plants.

Needed Sanitary Improvements in Mining Camps.....Dr C. M. Nice

The Facilities for Rendering First Aid and Further
Surgical Attention to the Injured in Mining
Camps Dr. J. F. Jenkins, Piper, Ala.Suggestions for Improvements of Surgical Facilities of
Mining and Manufacturing Industries.....Dr. W. H. BellThe Arrangements for Surgery at the Bethlehem Steel
Works Dr. W. F. Scott

MONDAY, JUNE 15.

Injuries to the Spinal Cord.

The Diagnosis of Cord Injuries.....Dr. B. L. Wyman

The Prognosis, with and without Operation, of Injuries of
the Cord at Different Levels.....Dr. H. E. Pressley

Report of Cases Collected in the Birmingham District—

Deductions.....Dr. E. M. Prince

MONDAY, JUNE 22.

Acidosis in Children.....Dr. T. D. Parke

Ptomain Poisoning.....Dr. J. R. Dawson

Lead Poisoning	Dr. Z. B. Chamblee
Delirium Tremens	Dr. O. P. Board

MONDAY, JUNE 29.

The Ovary.

Its Functions	Dr. W. P. McAdory
Conservative Operations on the Ovary.. ..	Dr. E. M. Robinson
Tumors of the Ovary—	
(a) Pathology	Dr. Robt. Nelson
(b) Treatment	Dr. Cunningham Wilson

MONDAY, JULY 6.

Clinical Meeting and Voluntary Papers.

MONDAY, JULY 13.

Chronic Lesions of the Urethra.

The Use of the Endoscope.....	Dr. C. W. Shropshire
The Occurrence and Treatment of Certain Minor Con- ditions	Dr. A. F. Toole
Chronic Specific Urethritis	Dr. J. E. Dedman

MONDAY, JULY 20.

Tubercular Lesions of the Throat.....	Dr. Geo. H. Stubbs
Tubercular Cervical Adenitis	Dr. S. H. Stubbins
Tubercular Meningitis—The Clinical, Bacteriological and Cyto Diagnosis	Dr. L. G. McCollum
Tubercular Joints	Dr. Ira J. Sellers

MONDAY, JULY 27.

Parotitis, Metastatic and Post Operative.....	Dr. Cabot Lull
The Present Clinical Value of the Opsonic Index....	Dr. M. H. Jordan
Diverticula of the Intestines and Their Relation to Obscure Abdominal Conditions	Dr. J. M. Mason

MONDAY, AUGUST 3.

Clinical Meeting and Voluntary Papers

MONDAY, AUGUST 10.

Typhoid Fever.

Etiological Factors—Infection Carriers.....	Dr. R. B. Harkness
Pathology	Dr. T. M. Barnett
Diagnosis, Clinical and Laboratory.....	Dr. F. A. Lupton
Hydrotherapy, Value and Methods of Application.	Dr. E. P. Solomon

MONDAY, AUGUST 17.

Typhoid Fever (Continued.)

- The Diagnosis of Intestinal Perforation.....Dr. W. M. Jordan
 Infection of the Biliary Passages Dr. Cunningham Wilson
 The Joints in Relation to Typhoid Dr. E. L. Scott
 Phlebitis Dr. T. L. Robertson

MONDAY, AUGUST 24.

- Mongolian Idiocy.....Dr. J. Ross Snyder
 The Effects of Uncorrected Refractive Errors on the Health
 of Children Dr. A. B. Harris
 Ear and Eye Complication of the Exanthemata.....Dr. R. C. Woodson
 Eneuresis Dr. E. H. Sholl

MONDAY, AUGUST 31.

- Causes and Diagnosis of Puerperal Infection.....Dr. E. S. Casey
 Treatment of Sapræmia Dr. Wyatt Heflin
 Treatment of Puerperal Sepsis Dr. E. M. Prince
 Treatment of Gonorrhea in Women Dr. A. G. Douglas

MONDAY, SEPTEMBER 7.

Clinical Meeting and Voluntary Papers.

MONDAY, SEPTEMBER 14.

- Autointoxication or Biliousness? Dr. E. P. Lacey
 The Differential Diagnosis of Enlarged Livers.....Dr. J. M. Killough
 Jaundice as a Disease and as a Symptom.....Dr. A. C. Cameron
 Medical Treatment of Gall Stones.....Dr. H. E. Mitchell

MONDAY, SEPTEMBER 21.

- Blood Pressure in Diseases & Injuries of the Brain...Dr. W. H. Wilder
 The Examination of the Eye Grounds in Diseases and Injuries
 of the Brain K. W. Constantine
 Decompressive Operations for the Relief of Intracranial
 Pressure Dr. Gaston Torrance

MONDAY, SEPTEMBER 28.

- Deformities of the Arch from Mouth Breathing..L. F. Luckie, D. D. S.
 The Deformities of the Nasal Septum in Their Relation to
 Mouth Breathing Dr. J. B. Greene
 Adenoids in Adults Dr. Carl A. Fox
 Immediate & Remote Results of Mouth Breathing...Dr. W. G. Harrison

MONDAY, OCTOBER 5.

Clinical Meeting and Voluntary Papers.

MONDAY, OCTOBER 12.

- Toxemia of Pregnancy Dr. Chas. Wheelan
 Extra Uterine Pregnancy; Symptoms and Diagnosis...Dr. L. C. Morris
 Treatment of Extra Uterine Pregnancy, with Report of
 Cases Dr. E. P. Riggs

MONDAY, OCTOBER 19.

Therapeutics.

- Rational and Empirical Dr. W. G. Harrison
 Therapeutic Conservatism and Nihilism Dr. H. N. Rosser
 Mysticism and Placebos Dr. R. M. Cunningham
 Prescription Writing vs. Ready Made Formulae.....Dr. J. M. Lowrey

MONDAY, OCTOBER 26.

- The Value of the Skiagraph in Diagnosis of Injuries to the
 Bones and Joints..... Dr. G. S. Brown
 The Xray in the Treatment of Skin and Malignant
 Diseases Dr. J. H. Edmonson
 Xray Dangers and Measures to be Adopted in Preventing
 Their Occurrence Dr. E. G. Northington

MONDAY, NOVEMBER 2.

Clinical Meeting and Voluntary Papers.

MONDAY, NOVEMBER 9.

Heart Diseases.

- Pericarditis Dr. R. T. Comer
 The Diagnosis of the Common Valvular Lesions.....Dr. H. S. Ward
 The General Management of Organic Heart Disease (the
 Schott and Nauheim Methods).....Dr. P. L. Cocke
 Angina Pectoris Dr. John W. Watts
 Myocardial Disease Dr. John Douglas

MONDAY, NOVEMBER 16.

- Disturbances Following Urates, Oxalates and Phosphates in
 the Urine Dr. Frank G. Grace
 Sexual Neurasthenia Dr. R. C. Bankston
 The Paralyzes of Infants and Children.....Dr. E. L. Scott

MONDAY, NOVEMBER 23.

- The Clinical Value of Ureteral Catheterization.....Dr. W. M. Jordan
 Acute Dilatation of the Stomach—
 (a) In the Course of Illness Dr. N. P. Cocke
 (b) As a Post Operative Complication.....Dr. Chas. Wheelan
 (c) Treatment of the Condition Dr. B. S. Lester

MONDAY, NOVEMBER 30.

Nephritis.

- A Study of the Comparative Value of the Urinary Finding of
 Chronic Brights Dr. H. K. Morrison
 Blood Pressure in Cardio-Renal Diseases....Dr. E. M. Mason, Montg'ry
 Recent Advances in the Treatment of Chronic
 Nephritis Dr. E. G. Little

MONDAY, DECEMBER 7.

Clinical Meeting and Voluntary Papers

MONDAY, DECEMBER 14.

- Normal Lactation Dr. H. Swedlaw
 Pathology of Tumors of the Breast.....Dr. Robt. Nelson
 Differential Diagnosis and Treatment of Tumors of the
 Breast Dr. E. P. Riggs
 Biers's Method of Treatment of Inflammations.....Dr. C. E. Dowman

MONDAY, DECEMBER 21.

Annual Meeting and Election of Officers.

MONDAY, DECEMBER 28.

- The Proper Relation of Laboratory to Bedside Methods of
 Diagnosis Dr. H. S. Ward
 Studies in Diseases of Metabolism.....Dr. J. S. McLester
 Studies in Pathology Dr. U. J. W. Peters

MONDAY, JANUARY 4, 1909.

Clinical Meeting and Voluntary Papers.

MONDAY, JANUARY 11.

- Medical Miscellany Dr. Geo. S. Brown
 Exact Hygiene in the Sick Room.....Dr. J. D. Heacock
 The Microscope in the Diagnosis of Fevers.....Dr. W. W. Compton

MONDAY, JANUARY 18.

Diabetes.

- Etiology and Pathology Dr. J. S. McLester
 Examination of Urine; Best Practical Qualitative and Quan-
 titative Methods Dr. U. J. W. Peters
 Complications and Their Treatment Dr. S. H. Mann
 General and Dietetic Treatment Dr. John A. Moore

MONDAY, JANUARY 25.

- Dacryocystitis Dr. S. L. Ledbetter
 Iritis Dr. K. W. Constantine
 Gonorrheal Ophthalmia.....Dr. A. B. Harris
 Gonorrheal Arthritis Dr. W. T. Berry

Correspondence.

To the Editor:

The management of a small pox epidemic is both difficult and expensive under our present system, and the health authorities get little credit and much criticism in their efforts to do the best that can be done under the power granted them by present laws on sanitation. We have no law compelling universal vaccination, hence a large number from choice are never vaccinated, and are a living menace to each other. There is no better established truth than that vaccination renders almost absolute immunity to small pox, and the people are fully advised of that fact everywhere but in the exercise of so-called personal privilege ignore the attitude of danger to themselves, their families and others, and recklessly refuse the protection offered. This is a subject upon which the people have had all the education they will accept; the doctrine has been daily propounded from Jenner's time to the present with little avail. More than half the people who submit to vaccination do so under protest, and feel that they are making a great concession to an unwise public sentiment.

I think that we have bombarded the opposition long enough from our present standpoint. Now let us change our tactics and place the responsibility where it belongs, upon the people. Extend a public invitation to every one to come forward and do their duty and be vaccinated; those who are not able to pay for the service will get it free. Let those who decline take their chances. Do away with pest houses or isolation camps, and let small pox patients roam at will. Those who have been properly vaccinated are in no danger. Let those who have declined to be take care of themselves in their own way. Many people have an idea that by some means they are going to be taken care of in spite of themselves. Let this class of people understand that no protection will be attempted against small pox save vaccination, and few will be left who will not avail themselves of the last and only chance of protection.

T. L. Robertson, M. D.

Birmingham, Ala.

Book Notices.

Syphilis. A Treatise for Practitioners. By Edward L. Keyes, Jr., A. B., M. D., Ph. D., Clinical Professor of Genito-urinary Surgery, New York Polyclinic Medical School and Hospital; Lecturer on Surgery, Cornell University Medical School; Surgeon to St. Vincent's Hospital. With Sixty-Nine Illustrations in the text and nine plates, seven of which are colored. D. Appleton and Company, New York and London. 1908. Cloth, \$5.00.

"A wearied medical public already surfeited with text-books, monographs, and essays upon syphilis and kindred matters, may well ask in resentful indignation: why this new work upon syphilis? Being the father of the writer and the godfather of many of the generalizations advanced, I think I may answer.

The facts upon which the volume rests are the classified cases from the private office books covering forty years of continuous work by myself along syphilological lines, ten years of work in the same field by my son, and some gleanings from the twenty extra years included in Dr. Van Buren's case books, which the office has inherited—making a retrospect of sixty years. In this considerable mass of experience there is much matter of value that would have remained buried but for the resurrection afforded by this volume."

Thus writes the father of the author, giving the reasons for this work. To express practically a view of syphilis that has been two generations in the making and to elucidate this by American statistics, seem to us sufficient excuse for the work, especially when so well and so interestingly written. The interest of the reader is secured in the first chapter, which discusses syphilis in relation to public health, and is held through subsequent chapters describing the general characteristics and the nature of the disease, its etiology, course, diagnosis, prognosis and treatment. The chapters on syphilis of the nervous system, and of the various organs of the body are equally interesting. The two last chapters discuss hereditary syphilis in utero and in infancy; its relapses, late lesions, diagnosis, prognosis and treatment.

Taken altogether the work is a most interesting and readable one on this important subject, and one well worth the buying and reading of every physician, whether general practitioner or specialist.

Miscellaneous Notes.

Dr. James S. McLester, 830 South Twentieth St., Birmingham, wishes to announce that he will be absent from his office for purposes of study October 1, 1907, to October 1, 1908.

Dr. B. D. Sibley announces that he has moved his office to the second floor of the First National Bank Building, rooms 227 and 228, where he will continue the practice of eye, ear, nose and throat work.

THE COUGHS FOLLOWING GRIP.

Dr. John McCarty (Louisville Medical College) in giving his personal experience with this condition, writes as follows: "Ten years ago I had the grip severely and every winter until 1902. my cough was almost intolerable. During January, 1902, I procured a supply of Antikamnia & Codeine Tablets and began taking them for my cough, which had distressed me all winter, and as they gave me prompt relief, I continued taking them with good results. Last fall I again ordered a supply of Antikamnia & Codeine Tablets and I have taken them regularly all winter and have coughed but very little. I take one tablet every three or four hours and one on retiring. They not only stop the cough, but make expectoration easy and satisfactory. The best results are obtained by allowing the tablet to dissolve slowly in the mouth before swallowing."

INDICAN COLOR SCALE.

Appreciating the diagnostic and clinical importance of the presence of an undue proportion of indoxyl-potassium sulphate (indican) in the urine and believing that anything that will be of practical assistance to the physician in the detection of same will be welcome by the profession at large, the manufacturers of Chologestin have prepared a color scale, graphically illustrating the gradation of color produced in the urine in varying degrees of indicanuria, as the result of the application of the most approved test, which is also fully described. A full and complete interpretation of the reactions accompanies the chart, which is an accurate reproduction, in colors, of actual specimens. The scale

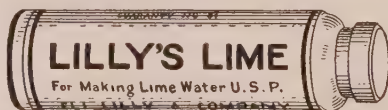
is issued on heavy paper, in portfolio form, so that the physician may preserve same for reference. As the edition is limited, the physician who desires a copy should write for same at once to

F. H. Strong Company.

53 Warren St., New York.

MAKING AND KEEPING LIME WATER OFFICIAL STRENGTH.

Lime water is a preparation of considerable medical importance. While it is comparatively easy to make it is not easy to keep at standard strength owing to its tendency to deteriorate. Physicians and pharmacists should remember that lime water is a solution of calcium hydrate $\text{Ca}(\text{OH})_2$, an unstable preparation which is quickly altered by the absorption of carbon dioxide which is always in the atmosphere to a greater or less extent. The atmospheric CO_2 is absorbed by the lime water changing the calcium hydrate to calcium carbonate (CaCO_3) which being insoluble is thrown down. Thus the lime water constantly loses strength unless there is an excess of calcium hydrate in the bottom of the container to replenish. The lime water tablet which is so convenient for making lime water is very unreliable because the calcium oxide of which it is composed, when fresh, is gradually changed to calcium carbonate through exposure to the atmosphere and lime waters prepared from the tablets are rarely full strength, even when first made. The pharmacopoeial process of making lime water from ordinary unslaked lime is tedious and laborious. Eli Lilly & Company are now supplying an especially prepared calcium oxide powder free from impurities present in ordinary lime and of a physical condition favoring immediate hydration and rapid solution.



This is a fine powder in hermetically sealed vials. Each vial contains a quantity sufficient to make one gallon of lime water of strictly U. S. P. strength, by following directions. By using Lilly's Lime no decanting is necessary and an official lime water can be prepared in in one half hour's time as against 24 hours required using ordinary lime. Lime water so prepared has been submitted to inspectors who

have found it meeting federal and state requirements. Ordinarily it is better not to make a larger quantity of lime water than can be used in a reasonable length of time, and it is important that the excess of lime be left in the bottom of the stock bottle to supply deficiency caused by the formation of calcium carbonate described above.

THE BORDERLAND OF DISEASE.

There is a growing tendency on the part of medical men to recognize the pathological importance of certain, at present, little understood conditions of the blood. Some of these indeterminable deviations from the normal present none of the aspects of the anemias, but nevertheless bear a direct relation to increased susceptibility to bacterial infection. The studies of Wright on the opsonins, so called, are of special interest in this direction, inasmuch as they have in a measure converted many of our abstract theories into concrete facts. That certain constituents of the blood may be diminished without apparent decrease of the corpuscular elements or of the hemoglobin, is at last fairly well established, and while the specific properties of these constituents are not as yet definitely known, there is abundant reason for attributing phases of malnutrition, as well as a general lowering of organic resistance to bacteria, to their absence or decrease. The clinical expression of this blood weakness, or chemico-physiologic deficiency, is subject to great variation, but the symptom-Complex usually consists of a general physical decline, loss of weight, increased tendency to fatigue, and a fickle or decreased appetite,—all of which go to make up a picture of what is usually loosely termed general debility. In addition, when the blood dyscrasia is marked, two objective symptoms are frequently noted. These are slight transitory enlargement of the cervical lymphatics, and a marked susceptibility of the skin to abrasions and infection. Simple injuries produce wounds that heal poorly and the processes of repair seem to be very feeble and inadequate.

This then in a general way constitutes what may be called the borderland of disease, a condition which even if it does not always precede tuberculosis, typhoid fever, pneumonia and many other diseases, certainly favors their development and tends to increase their severity.

The correction of this indefinite but none the less dangerous state of the blood is always urgent, particularly because of the favorable opportunities presented for increasing the resistance to those to which it predisposes.

Regulation of the diet, careful attention to the personal hygiene, and as much outdoor living as possible are the essential features of the careful treatment of this condition of blood depravity. A good tonic is quite necessary in connection with the foregoing, and Pepto-Mangan (Gude) has been found very effective. Its pronounced hematogenic action is well-known, and the rapid hematosis which result from its administration unquestionably has a decided influence in coincidentally raising the relative immunizing power of the blood. Reparative processes in wounds are stimulated, simple glandulous swellings disappear, and tangible improvement in the general bodily nutrition rapidly follows. All this is accomplished, moreover, without placing the slightest tax on the digestive tract, and the patient is thus able not only to derive the fullest benefits from every effort in his behalf, but the course of his recovery is progressive and unbroken. His vital resistance is materially raised and the balance of functional vigor restored to the normal. That the extent to which this is accomplished measures the decreased liability to infectious disease, can no longer be doubted.

Leucorrhoea exists, or has at one time, in fully 50 per cent. of our women. Wealth and splendor possess no bar to its entrance, it attacks rich and poor alike. The woman of leisure is even more apt to be afflicted with it than her humble domestic, but all, in their characteristic manner, in a measure endeavor to keep the fact from their attending physician. As said, however, this condition seems to be undergoing a change, and these cases are daily becoming more frequent to the family physician. Dr. J. D. Albright says: One of the most troublesome cases I was ever called upon to treat was one of ever and recurring liability to faint, in a lady who formerly had an attack of endometritis, which had been entirely cured, but which left a stubborn leucorrhea in its wake. The curing of this latter trouble has made my patient strong, and entirely removed the fainting tendency. In a severe case of the combination of these two affections, after exhausting almost the entire materia medica, without more than temporary relief, I found an excellent remedy in Tyree's Antiseptic Powder, which gave immediate relief, and resulted in permanent cure. A trial package will be mailed free of charge to physicians if they will send their name and address to Mr. J. S. Tyree, Chemist, Washington, D. C.

ERYSIPELAS-PNEUMONIA.

W. E. Storfe, M. D., Martinville, Ohio.

June 5, 1905, I was called to attend Mr. K. I found him suffering with a very aggravated case of facial erysipelas. I applied my usual treatment of carbolyzed salve locally, and gave the proper internal treatment, but when I saw the case again in twenty-four hours I found symptoms no better. I thought I would try Antiphlogistine. After applying the salve to face, I spread Antiphlogistine on a cloth making a mask that would cover the entire face, directing nurse to change when it dried out.

Next day I found patient much improved. He said "that clay relieved all the burning five minutes after you applied it." I now make it a rule to use Antiphlogistine in treating erysipelas, and I am sure my patients get along faster than they did when treated without it.

I also use Antiphlogistine in pneumonia, and all cases of inflammation of the lung or pleura. Indeed I would hate to have to treat this kind of cases without Antiphlogistine. I will report on one case of an infant where I believe this remedy saved the patient's life.

Jan. 3, 1906, infant, age 18 months. Two days after initial fever, temp. 104° resp. 48, pulse 129, tongue coated, could hardly get breath, expiratory moans, crepitant rales. Gave internal treatment, and covered both back and front of chest with Antiphlogistine. In twenty-four hours the breathing was much better and temperature lower. On my third visit I found all the symptoms so improved that I dismissed case.

DR. H. MARION SIMS,

the father of gynaecology, said: "For severe dysmenorrhea, I have found Hayden's Viburnum Compound of great service." See notes by Marion Sims. Vol. No. 2 of Grailly Hewett on Disease of Women.

Few drugs employed in the treatment of diseases of women have the commendation of so excellent an authority and like expressions since the time of Sims have been uttered by many of the best men in the medical profession.

Hayden's Viburnum Compound has stood the test of time for twenty-six years and is the recognized standard Viburnum product by which imitators would measure.

In the treatment of DYSMENORRHEA whether of congestive, neuralgic or membranous type, Hayden's Compound acts most promptly and effectively.

In MENORRHAGIA where the flow is excessive as a result of any one of the several causes, Hayden's Viburnum Compound affords relief by imparting tone to the uterus and stimulating its contraction. Clinical evidence has conclusively proven that it is as effective as ergot without possessing the narcotic or dangerous properties of this drug.

IN OBSTETRICAL CASES, Hayden's Compound is of particular service. It modifies the pangs of childbirth by its soothing effect upon the nervous system and by its anti-spasmodic action upon the uterus, making it particularly serviceable in cases of rigid os. On account of the reputation of Hayden's Viburnum Compound, it is extensively imitated, however, only when the original Hayden's Viburnum Compound is prescribed can you be assured of definite therapeutic results.

RESPIRATORY TRACT: AFFECTIONS, SYMPTOMS AND TREATMENT.

By Arthur B. Smith, Springfield, O.

The average physician is frequently vexed in finding a condition which resists his best efforts to bring about a cure. This holds good in almost every disease at some time or other, but particularly in affections of the respiratory tract, where there may be a great variety of symptoms in several cases of the same disease.

Almost every physician has some favorite prescription for coughs, bronchitis, laryngitis, etc., which he uses until suddenly it seems to lose its efficacy—why, no one knows. Then another remedy takes its place until it, too, fails to give the desired result. It is rarely that one finds a cough remedy which will be consistently good in the majority of cases. Theoretically there appears to be a well-founded objection to the use of cough syrups in general, but nevertheless, there are times when nothing else gives satisfaction; therefore, the physician pins his faith to that remedy from which he and his patients derive the most good. It is not always easy to find such a remedy, but when it is once found, it is equally difficult to dispense *with*, and often the physician is almost compelled to resort to a routine treatment. In such cases, of course he wants the best.

There are constantly being placed on the market new formulas for affections of the air passages. Some of these formulas are of undoubted benefit in some cases, but usually it will be found that the results are far from satisfactory. Many of them cannot be taken when there is any gastric complication, as is sometimes the case, because of consequent nausea and vomiting. Others seem almost invariably to act as cardiac depressants and are highly objectionable for that reason.

In phthisical patients the well known lack of appetite and intolerance of various foods render it imperative to give remedies which will not in any way interfere with the digestive functions, while at the same time controlling or alleviating the cough and other distressing conditions.

Some time ago my attention was called to a preparation composed of a solution of heroin in glycerine, combined with expectorants, called Glyco-Heroin (Smith). Each teaspoonful of this preparation contains one-sixteenth grain of heroin by accurate dosage. It is of agreeable flavor, therefore easy to administer to children, for whom the dose can be easily reduced with any liquid, or by actual measurement. It possesses many advantages not shown by any other preparation I have used, and has none of their disagreeable features.

In citing some of the cases treated with this remedy I shall not go into a minute description of any case, but briefly state the conditions which existed and the results obtained, which were uniformly good.

Case 1. S. B., age 16. Caught a severe cold while traveling. This developed into an unusually severe attack of bronchitis with mucous rales, pain cough and some slight fever. Prescribed Glyco-Heroin (Smith) one teaspoonful every two hours, decreased to every three hours. After a few doses were taken there was a decided improvement, the respirations were slower and deeper, the expectoration freer and the temperature normal. In a few days the patient was practically well and able to return to school. No medicine except Glyco-Heroin (Smith) was given and the results from its use were excellent.

Case 2. W. L., aged 31. Acute bronchitis. Painful cough, with difficult expectoration, particularly when in a reclining posture. Glyco-Heroin (Smith) in teaspoonful doses every three hours gave speedy relief and a cure was effected in a few days.

Case 3. B. E., aged 26. Severe bronchitis accompanying an attack of influenza. Various remedies were tried in this case, with negative result, until Glyco-Heroin (Smith) was given in teaspoonful doses every three hours. In a short time decided relief was obtained and the cough stopped permanently.

Case 4. R. L., aged 6. Capillary bronchitis with pains over chest, cough and difficult expectoration. Glyco-Heroin (Smith) administered 15 drops every three hours. After taking a few doses the condition was much improved, and a speedy return to perfect health followed.

Case 5. W. H., aged 5. Whooping cough. Spasmodic paroxysms of coughing, sometimes being so severe as to cause vomiting. Tenacious mucous was present, requiring great expulsive effect to loosen it. There was little fever, but the patient was much prostrated and weakened by the cough. Glyco-Heroin (Smith) was given in 10 drop doses every two hours with good results. This was combined with hygienic treatment, the patient being given as much of fresh air as possible. In a few days the condition was much ameliorated, the cough under fair control, expectoration was freer and easier to raise, and convalescence uneventful. The case was discharged cured and there were no unpleasant sequelae, the patient at present being in perfect health.

A WORD FOR PASSIFLORA.

"I have lost considerable time and caused many of my patients to suffer more and longer than they should have done, by virtue of my ignorance of Daniel's Concentrated Tincture Passiflora Incarnata. In my practice I consider your Passiflora a good stand-by, casting abominable opiates entirely out of use. In looking back over my past and that of other physicians in my locality, I can see wrecks resulting from morphine and opium, that would not have occurred had we gotten out of the old rut and accepted the remedy God designed for the nervous system. I regard it as invaluable for neurasthenia, insomnia and similar affections, and shall always prescribe it with the utmost feeling where ever indicated, and feel confident of success."

Tulsa, Okla.

J. B. Morrow, M. D.

EPIDIDYMO-ORCHITIS COMPLICATING TYPHOID FEVER.

Charles M. Nice, M. D., Birmingham, Ala.

The following case is reported because epididymo-orchitis is a comparatively rare complication in typhoid fever, being discussed by most writers as orchitis, occurring after convalescence has begun, and usually with a previous history of specific urethritis. This case is unusual in its differences.

History.—L. B., white, male, aged 25, book-keeper, was seen Sept. 28, 1907. The family history was negative. He was of good habits and did not use alcohol or tobacco. He had had the diseases of childhood but no serious illness. He positively denied a history of urethritis or other venereal disease. His present illness began with an attack of typhoid fever of mild type beginning six weeks previously. Temperature reached normal on twentieth day. Four days later, after indiscretion in diet, he suffered a relapse. This was uneventful with the exception of frequent attacks of marked pain over a greatly enlarged spleen until the nineteenth day of the relapse when the temperature appeared to be decreasing. On the morning of this day the temperature, which had been following a downward curve from 103 F., had reached 99.2 F. In the afternoon it was 102 F. and the following morning 103.5 F. At this time patient complained of dull, aching pain in scrotum.

Examination.—Examination revealed an enlarged, purplishred scrotum. The right testicle was twice its normal size and exquisitely tender. The following morning, the temperature was 103 F., the testicle had increased in size, with tenderness most marked over the postero-inferior pole and along the enlarged spermatic cord. The testicle and epididymis now formed a mass the size of a goose egg.

Treatment.—Under treatment consisting of elevation and evaporating lotions of lead water and laudanum, the condition began to subside and three days later, after a septic run, the temperature reached normal. The patient's convalescence and recovery was otherwise uneventful.

Since the urinary examination was negative, it seems probable that the infection was due to the typhoid bacilli and through the vascular route. It is a mooted question as to whether the epididymis or testicle bears the primary infection. From examination it seems probable

the testicle was first involved here. The prognosis in this condition is good inasmuch as suppuration is rare. The treatment is that of an ordinary orchitis.—*Jour. A. M. A.*

NASAL CATARRH.

By C. W. Canan, A.B., M.D., Orkney Springs, Va.

Chronic nasal catarrh is for convenience divided into three stages or varieties: (1) Simple Rhinitis, (2) Hypertrophic Rhinitis, (3) Atrophic Rhinitis. In the first form there is a simple chronic inflammation of the pituitary membrane, uncomplicated by serious structural changes, but attended with a discharge of mucous or muco-pus. When this condition is allowed to continue for any considerable length of time structural changes take place in the mucous membrane and we have hypertrophic rhinitis as the result. There is usually an excessive secretion of thick tenacious mucous which more or less occludes the nasal passage. Enlargement of the adenoid elements in the adjacent parts of the pharynx coexist as a rule. In this form of the disease the inferior turbinated body suffers the most frequently and to the greatest extent; this in turn may irritate the neighboring pharyngeal parts, leading to chronic pharyngitis, catarrh of the eustachian tube and even chronic laryngitis. The third form of the disease or atrophic rhinitis follows as a sequence of the former or second variety. It is the result of contraction of fibrous tissue previously formed upon and around the vessels and glandular structures and consequently their obliteration. The membranes are dry and covered with dry scabs and muco-pus which become more offensive and abundant as the disease progresses. The olfactory sense may be partially or wholly lost.

We give this brief history of pathology to prove that a case of simple nasal catarrh may turn out to be a grave disease in the end if not promptly recognized and properly treated. "Clean up and keep clean" should be our motto. The remedy best suited for this purpose should be one that is alkaline in reaction, non-irritating and contain enough antiseptic qualities to disinfect the nasal cavity without producing toxic symptoms. The remedies that have been in general use are carbolic acid, acid salicylic, acid boracic and sodii bicarb. in solution or in combination, but we have found a remedy that surpasses these, as well as all others in results. This is glyco-thymoline. This remedy

can be used in all per cent solutions up to the plain drug, according to the sensitiveness of the nasal mucous membrane and the condition for which it is prescribed. In the treatment it is necessary to remove all pus, mucus, scabs, scales and dead bone if any be present. To remove all these except the last, glyco-thymoline should be used through a syringe until the entire tract is clean, then if there be any specially diseased points it should be applied to them in full strength. In all mild cases of catarrh a thorough cleaning with this remedy and keeping the cavity scrupulously clean afterwards with same will be all that is necessary to effect a cure. That the reader may better understand the value of this remedy in this disease we will report the clinical history of a few cases selected from our notes.

Case 1. Mr. F. M., farmer, age 37, presented the following history: At times the nasal secretions were profuse and mixed with pus, at others the nose was very dry and breathing was difficult. Examination revealed a highly sensitive mucous membrane thickened and congested. The mucous follicles on the post-pharyngeal walls were also enlarged and secreted a tough tenacious mucus which kept the patient hawking to clear his throat. Diagnosis: Chronic rhinitis. Treatment consisted in cleansing the canal thoroughly with a twenty per cent solution of glyco-thymoline. The patient was then instructed how to douche the nose night and morning with the above solution and return once a week to my office. Improvement was rapid and at the end of one month patient was dismissed.

Case 2. Miss M. P., housekeeper, age 22. Good family history. Last March she contracted la grippe in a severe form following which more or less nasal trouble was in evidence. There were periods of sneezing, dryness and a decided flow of clear liquid. At times the dryness was so marked that she could not breathe through her nose. Finally the watery discharge became bloody and at times contained pus. Headache developed, head noises, dropping into throat and many other symptoms. Examination showed a highly congested pituitary membrane, while the anterior cavity was filled with dead scabs and scales. The lining to the eustachian tubes was so swollen that it was impossible for air to reach the middle ear. Diagnosis: Chronic rhinitis. Treatment consisted in thoroughly cleansing cavity with a twenty per cent. solution of glyco-thymoline. When all the scabs were re-

moved the pituitary bodies were touched with the drug in full strength; the bag was then used to inlate middle ear and the nose and throat sprayed with the atomizer. Patient was instructed how to cleanse nasal cavity with the remedy three times daily and to come to the office twice a week. The improvement was decided from the time of the first treatment and in six weeks there was not a trace of the disease.

Case 3. Miss Lizzie R., age 16 years. She was very much reduced in flesh and was very anemic, complained of attacks of sneezing in which she would sneeze from eight to twenty times before she could stop. Nose would discharge freely, then become very dry. She also also sufered from headache, giddiness, and a continuous full feeling between the eyes. There was dropping into throat at times and she had a troublesome cough with sheezing in chest. The mucous membrane was highly congested, covered in places with scabs and tough mucous that was difficult to dislodge. A deep angry ulcer presented on the anterior surface. There was also a pharyagitis and laryngitis and catarrh of the eustachian tubes. Diagnosis: Chronic rhinitis complicated with pharyagitis and laryngitis. Treatment was same as in case second except throat and larynx were sprayed daily with glyco-thymoline. Patient was also placed upon Fowler's solution three times daily after meals and Cod Liver Oil one hour after meals. The condition showed marked improvement after the second week and at the end of another week patient was entirely well.

THE NATURE AND TREATMENT OF DROPSY.

By Dr. Thomas Hunt Stucky, A. M., M. D., Louisville, Ky.

Formerly Professor of Theory and Practice of Medicine and Clinical Medicine, Hospital College of Medicine, Ex-President Mississippi Valley Medical Association.

The term dropsy is one which is rather loosely applied to any abnormal accumulation of watery fluid in the body. In more concise technical language we use the word edema when the fluid occurs within the interstices of tissue and ascites when it is free in the abdominal cavity. For accumulations in other cavities special names are used, as hydrothorax, hydropericardium, hydrocephalus, etc.

Edema of the subcutaneous cellular tissue is a very common form of dropsy; it is usually confined to certain regions, but may become gen-

eral, in which case it is referred to as anasarea. The site in which edema most frequently occurs is in the feet and ankles; next to this is the region about the lower eyelids.

In a normal state of health there constantly exudes from the blood vessels, especially the capillaries, a fluid derived from the serum of the blood. This percolates between the cells of all tissues, and is the means of carrying nourishment to all those cells which are not in direct contact with blood vessels. These interstices between the cells are drained by the vessels of the lymphatic system, which are able to carry off easily all the fluid which comes to them under ordinary circumstances.

The composition of this lymph is very nearly the same as that of the serum of the blood. It contains a larger proportion of water and only about three per cent. of proteids. As a rule it contains no fibrin, although it will coagulate upon the addition of fibrin ferment, showing the presence of some of the fibrin elements. Its specific gravity will average about 1.015.

Cohnheim taught that the most important factor requisite to the production of dropsy is malnutrition of the walls of the blood vessels. It is well to keep this in mind, for although in most cases the other causative agents are much more evident yet this element of malnutrition will almost certainly be found to exist in a greater or less degree. It can readily be imagined that the single layer of delicate cells which form the wall of the capillary vessels would be very sensitive to changes in the blood which is constantly passing them. In diseases of the kidneys, the liver and other excretory organs a number of poisonous matters accumulate in the blood to an abnormal degree, and they can not fail to harm this lining membrane. Fevers of all kinds, the presence of bacteria, pus or other products of microbic invasion will produce the same effect. Of course, in these diseases we do not often have dropsy, but the endothelial membrane is in a weakened condition, and a comparatively slight determining cause will bring on this symptom.

An excess of blood in the part may produce an edema. When it is caused by over-distention of the arteries the liability to edema is not so great as when there is a venous stasis. In the former case the capillaries are constantly receiving plenty of fresh blood, while in the lat-

ter the same blood remains in the vessels and the endothelium derives but little benefit from it. Valvular diseases of the heart is one of the main causes of a general slowing of the blood current and especially of the venous stasis. The pressure from behind, the *vis a tergo*, of the blood in the veins is never great under the best of circumstances, and when the power of the heart is weakened from any cause this propelling force is reduced to a very low point. In valvular disease of the heart the amount of blood passed through this organ is diminished until a compensatory hypertrophy is established. In the meantime the blood in the veins being impeded to some extent in front and not forced from behind, flows very sluggishly.

In the legs the blood has to mount some distance against the force of gravity, which greatly retards the circulation. While the patient walks about vigorously the contraction of the muscles of the legs, by pressing upon the vessels, helps to force the blood forward; but such patients can rarely walk with any great amount of vigor, the blood does not receive this extra help, and an edema of the feet and ankles is almost sure to be seen at some stage of the case. At first this is merely a puffiness observed at night after being up all day. The condition spreads from the feet up the legs, becoming greater as the case progresses. After a time the swelling is not entirely reduced even after a night's rest; the parts feel cold and pit upon pressure, the dents remaining for quite a length of time. Unless the case is treated properly this edema will finally involve a large portion of the body, it is an expression of extreme weakness of the circulation, and is rightly regarded by the laity as a very grave symptom.

Allied to this condition in certain ways is the accumulation of fluid in the abdomen. This escapes from the vessels of the mesentery and intestines; it is seen in conjunction with dropsy in other parts, and may come from the same state of cardiac weakness which causes edema of the feet. In many instances, however, it has a special cause in an obstruction to the flow of blood through the liver. As is well known, all of the blood from the stomach, small intestine and most of the colon is gathered up into the portal vein and goes through the liver. Whenever there is any obstruction in this organ the blood is dammed back into the other viscera and its fluid oozes out into the general peritoneal cavity,

A state of inflammation of the liver, bringing an abundance of leucocytes to the organ and causing a swelling of its cellular portion, produces a compression of the blood vessels, thus impeding the circulation. In chronic inflammations the overgrowth of the connective tissue has the same effect, but it is carried to a greater degree. In this disease the lumen of the blood vessels is sometimes almost obliterated, and it is in such cases that we find persistent dropsy in the abdomen.

In diseases of the kidneys a large proportion of the poisonous matters which these organs should excrete are allowed to remain in the blood. These injure the walls of the capillaries, as referred to above, and the dropsy first seen in these cases is probably purely from this cause. Later on these same poisons affect the force of the heart muscle and weaken the nervous system, so that we may readily see how a part of the general anasarca sometimes observed in such cases may be due to circulatory weakness.

The general treatment of these cases depends, of course, largely upon the cause. Where the heart alone is at fault the patient should be put to bed, or at least confined to a chair if he can not lie down with comfort, as frequently happens. Efforts must be made to increase the nutrition of the heart muscle and the efficiency of its nerve supply. To this end we must attend to his diet; such patients have a poor digestion and often have diarrhea. The most nourishing and easily digested foods must be given, in as great an amount and at as short intervals as he can digest them. Tonics for the heart and nerves must be administered, but care and judgment must be observed in their use, for there is grave danger of stimulating the heart beyond its strength.

Digitalis and strychnine are powerful drugs, and their effects must be watched constantly. I have had better results with a preparation called anasarcin, which is a combination of several mild tonics, alteratives and diuretics. It is a much safer drug to leave with the patient, and is very reliable in its action; its diuretic effect is one of the best means of reducing the dropsy.

Cases of renal dropsy are frequently helped by the saline purgatives and by any measures which increase the amount of perspiration. The poisons which should be eliminated by the kidney can in a large measure escape through the bowel and the skin, and these means must be used to the point of endurance. As the circulation is always weak

it is necessary to administer cardiac and general tonics, and for these patients the same drug, anasarcin, is probably more efficacious than any other.

For dropsy into the abdomen the diuretic action of anasarcin and its tonic effect make it the remedy on which I have depended.

This seems high praise, but the favorable opinion formed will be found in the histories of cases given below, which are only a few chosen at random from my practice during the past year:

Case 1—Mrs. E., married; physical examination, aortic stenosis; no doubt of long standing. Goitre from pubescence. During first pregnancy developed acute nephritis with pronounced general anasarca. Usual remedies tried unsuccessfully. Anasarcin recommended; tablet to be used every three hours. After three or four days treatment, marked diminution of the dropsical effusion, which being carried on during the remainder of gestation, enabled her to go through the parturient period successfully. There have been several returns of the dropsy since this attack three years ago, all of which yielded promptly by the use of this remedy.

Case 2—Mrs. F., widow, age 67 years. Mitral regurgitation. Chronic interstitial nephritis; general anasarca, with all accompanying and distressing symptoms. Diuretin, infusion digitalis and the general agents proved unsuccessful. Anasarcin, one tablet every three hours encouraged by the use of salines produced decided relief to such an extent that the patient is now going about in comparative comfort.

Case 3—Edwin R., aged 18 years. History of scarlet fever when seven years of age. Aortic regurgitation during attack of scarlet fever with general anasarca which only partially disappeared after months of confinement with the usual remedies. Was placed upon anasarcin six weeks ago; one tablet every three hours until active elimination was secured both by kidney and bowels; then a tablet three times a day. At this time, August 2, 1907, there is no evidence of any dropsy, and to all appearances he seems to be regaining his strength rapidly.

Case 4—John R., 42 years of age. Has been a spreer. Hypertrophic cirrhosis of the liver. Mitral regurgitation; albumen, hyaline casts and granular casts found in the urine. The effusion was so great into the abdominal cavity that it was necessary to aspirate. Four gallons of fluid withdrawn, producing very decided relief, showing evidence a few days thereafter of the return of the edema. He was placed upon

anasarcin as above described, in connection with tonics, and has been comparatively comfortable ever since. My observation has been that this agent is serviceable in all dropsical conditions, irrespective of cause—with the exception of those which are entirely mechanical in character.

FIFTH PAN-AMERICAN MEDICAL CONGRESS.

To the Medical Profession.

Gentlemen:—The government and the people of the Republic of Guatemala, as well as the national committee of the Fifth Pan-American Medical Congress are actively endeavoring to do all in their power, in a sure and efficient way, to make this meeting a great success.

With this object in view the committee will be pleased to invite you personally to attend, as well as the members of the society or medical fraternity to which you belong, in order that through your presence and works the certain success of the Congress, that science expects of its representatives will be assured.

The committee hopes that you and the other members of your institutions will meet at Guatemala on the 5th, 6th, 7th, 8th, 9th and 10th of August of this year, 1908, and sincerely begs that from now on you will not hesitate to keep yourself in fraternal relations with this committee, and also that you will let us know before hand if you intend to attend the Congress in person or to send some scientific contributions.

The committee hopes to receive a reply shortly to this invitation to the meeting, which should serve as an incentive to unite professional interests, to stimulate the advance of medical science and to contribute to the preservation of the health and the prolonging of the life of the people of the Americas.

We take advantage of this opportunity to express to you the best regards of

Yours very truly,

Juan J. Orteaga, Pres.

Jose Azurdia, Sec'y.

It must not be thought that Guatemala is an undersirable place to visit in August and that it will be very hot and the rain constant.

August is the time of the year called the cunicula, when, although hot there is but very little rain. The heat of Guatemala does not however compare with the heat of our own states as it is situated on a

plateau which is comparatively cool. The trip down from New Orleans or from New York by steamer to Porto Barrios is an agreeable one. The trip to the Congress and back will be in the hands of the chairman of the transportation committee. Excursions can be made also in connection with this Congress to Mexico or the various West Indian Islands. The excursions will be in the hands of Thomas Cook & Co. or any one who chooses to organize one. There will be no charge for transportation in the Republic of Guatemala.

THE EVENING OFFICE HOUR.

Picture a hot August evening when the air within doors, doubly heated by the gas-light or the kerosene lamp, is almost intolerable; picture a man whose bearing indicates him to be of more than ordinary prominence in his community and whose appearance of prosperity indicates that he is beyond the reach of want; picture this man on this intolerably hot night, seated in a stuffy, foul-smelling office—sweating and sweltering—longing to be at his home or out in the fresh air and moonlight—and you have pictured what may be found in over a hundred thousand physicians' offices throughout the United States during any hot, August evening. Gentle reader, this is the highly-respected, and generally sane and intelligent doctor "*Keeping his evening office hour!*" The sympathetic layman—the imaginative laywoman with unstable nerves—will look upon this function as a part of the useful life of the "over-worked physician;" but the fellow practitioner, who, through some fortunate inspiration has broken away from the bondage of the evening office hour, will look upon the sweltering doctor as a misguided "captive fettered at the oar of gain," or as an unreasoning slave to tradition and custom.

It is unquestionably true that, in some conditions and in some classes of practice, the evening office hour is more or less a necessity; but such conditions are rare and such classes of practice are, fortunately, quite exceptional. For the most part, the evening office hour is a burden which is self-imposed; which is detested by every physician of broad and healthful mind and which, incidentally, may be dispensed with by the exercise of a reasonable amount of initiative and judgment. The vast majority of medical men who spend the best part of each evening in the office, thereby depriving themselves of proper

and healthful diversions and amusements and their families of their society, realize that there is no absolute necessity for the custom they follow and know, further, that it is not even reasonably profitable.

Tony, my barber, spends his evenings as he chooses; Jim, the affable bartender, up the street, works at night, it is true; but Jim sleeps by day. Smith, our little green grocer, keeps open shop on Saturday evening, but the other six evenings he is free. At my lodge, which is cosmopolitan in its personnel, I am the only one who must come late if at all—the others, after the clock strikes six, are freemen and gentlemen. And worst of all, there is no virtue or reason in my cause. The best that can be said of my evening office hour is that through it I may be able to squeeze out another dollar or two while other men are enjoying rest and home and family.

My colleague, whose practice is amply large to support him in comfort, tells me that he has kept accurate count of the money he has made during his evening office hours, *which he would not have received* had his office been closed in the evening. In three months, this amounted to the sum of twenty-eight dollars! I am not a spendthrift. My estimate of the value of a dollar is as high as that of any man whose soul is not steeped in avarice. However, the liberty and comfort and peace to be derived from thirty evenings at home are worth more to me than nine dollars. While we may be members of an “underpaid profession,” we are not, as a rule, in such dire poverty as to necessitate sacrificing our liberty, recreation and our home life for such a pittance as this. Yet it is a question whether any physician of first-class practice really makes more than a pittance, which he would not otherwise receive, through the evening office hour.

But if the sacrifice of our evenings is not made for the miserable compensation it produces, what is our excuse for keeping up this custom? Our idea of pleasure cannot have become so misshapen that we believe we enjoy it. Can it be that the homes of doctors generally are so unattractive that the pill-shop is preferable to them? Can it be that doctors have no friends? Have we become so narrowed by our labors that we think pills and dream emulsions and exclude from our minds other more healthful things? Are we blind slaves to the one monumentally assinine custom inherited from our forefathers? Or are we afraid that, if we do not haunt our offices by night as well as by

day, some other doctor may get some tramp of a patient who is not worth the getting anyway? Frankly—and I say it with some shame and humiliation—from my conversations with a number of physicians, I am convinced that the fear that others may profit, (not that we may lose), is the thing that keeps us, year in and year out, victims of this senseless practice which renders a peaceful evening meal impossible, which makes the doctor a stranger to his own children and which deprives him of the broadening and healthful social contact with his fellow men.

It is superfluous to argue the practical phases of the thing, or how the evening office hour may be avoided. These things were solved years ago by merchants who then believed that weekly half-holidays would mean financial loss. The abolishment of the evening office hour would mean no more monetary sacrifice on the part of the doctor than the half-holiday to the merchants. Their result was an actual profit.

The life of the doctor is hard enough without this senseless self-imposed burden.—*Chicago Clinic and Pure Water Journal*.

THE BEST STORY OF THE YEAR—SO FAR.

The year 1908 is still comparatively young, so it is quite possible that during it we may be afforded an opportunity of reading a narrative superior in workmanship, in interest, and in delicate character drawing to Marie van Vorst's new novel, "The Woman He Loved," but we are quite positive that none has appeared as yet. This latest story by the author of "Amanda of the Mill," "When Spring Comes Late," and other successful novels, is published complete in the February issue of *Lippincott's Magazine*. It has for its central figure Jimmy Bulstrode, a character who has already appeared in two shorter stories published in *Harper's* and *Scribner's* and readers of these magazines will doubtless be glad to renew their acquaintance with him. The scenes of the story are laid in England, at and about the castle of the Duke of Westboro'. The Duke and his American Duchess have quarreled and separated, but are brought together again through the kindly efforts of Bulstrode, who longs to see his friends happy, even though he cannot be quite happy himself—for he is in love with another man's wife. Like in all of Miss van Vorst's work, the dominant quality of "The Woman He Loved" is its exceeding naturalness. Among the shorter stories,

"Rakes," a vivid and dramatic tale of war in the far East, by Will Levington Comfort, stands out as worthy of special mention, as do "A Story That Went Wrong," by Thomas L. Masson; "The Questionings of Don," by Minna Thomas Antrim; "Mrs. Weimer's Gift of Tongues," by Elsie Singmaster; and "The Widow Smith's Dog," by William R. Lighton. A very striking special article is that on "The Twentieth Century Jew," by Ezra Brudno. Dr. George Lincoln Walton continues his series of papers on "Worry and Allied Mental States" with an article on "Sleeplessness," which should be read by all who suffer from this annoying malady, or who have any friends who are thus afflicted. Robert Gilbert Welsh, Joseph M. Rogers, Bonnycastle Dale, and Ellis O. Jones contribute entertaining essays on various topics to the department "Ways of the Hour." Some delightful poetry and "Walnuts and Wine," the most widely quoted humorous section published, complete the number. It is an exceptionally well balanced and readable magazine.

PREVENTION OF DEATH DURING ANESTHESIA BY CHLOROFORM AND ETHER.

Robert Reyburn of Washington believes that deaths from anesthesia are due to the neglect of certain precautions, and these he endeavors to point out. Death by ether is either speedy, resulting from the too concentrated ether vapor, inhaled, or delayed, when it results from nephritis due to prolonged inhalation. The cone used should be of the simplest and the anesthetist a trained one, not an undergraduate. When death results from acute nephritis it is due to the large amount of ether absorbed by the blood in the renal artery, one of the largest branches of the aorta. Death may result from too great absorption of ether into the lungs, producing bronchial irritation and pneumonia. A third late form of death results from acute fatty degeneration of the liver. Sudden death is believed by the author to be from the column of venous blood filling the jugular and innominate veins, and this pressing upon the auricle and preventing it from opening. The first treatment, then, is the inversion of the patient so as by gravity to open the auricle. The ether should be given drop by drop. The operation should be as short as possible. A faradic battery should always be ready to stimulate respiration, and artificial respiration in the prone position should be at once performed.—*Medical Record*, January, 18, 1908.

ANORECTAL FISTULA.

Charles B. Kelsey of New York says that fistula implies chronicity, induration, and canalization, with shrinking of the original abscess cavity to a canal. Fistulae almost never heal spontaneously. In the diagnosis of the different varieties the probe is not sufficient. Gentle digital examination is valuable. Superficial fistulae are below, and deep ones above the sphincter ani. Superficial fistulae may be treated by cauterization and drainage with some success; in general cutting is necessary, but should be done so as not to produce incontinence of feces. The muscles should be cut as little as possible, and then across, not diagonal to, the fibers. Tuberculous fistulae are diagnosed by several large external openings, violet-colored skin, studded by tubercles, and unhealthy sanious discharge, destitute of repair. Treatment demands thorough cauterization, and treatment of the general health. Incontinence may be obviated by exposing the ends of the muscle and suturing them carefully. Plastic operations may be necessary, and strips from the glutei are best used, crossing to the opposite side of the rectum. Deep fistulae arise from disease of the female genital organs, prostate seminal vesicles, and urethra in men. They demand laparotomy to remove the cause of the abscess. Colostomy may be the only resource, rest of the bowel accomplishing end sought.—*Medical Record*, January 18, 1908.

WRITER'S CRAMP: WHAT IT IS AND HOW IT CAN BE TREATED BY THE FAMILY PHYSICIAN.

S. H. Monell of New York believes that writer's cramp is the result of chronic fatigue of the muscles and should be treated as such. The poisons of combustion cease to be eliminated, and they enfeeble and irritate the muscles and nerve fibers, and this results in pain, heaviness, stiffness, and other symptoms. The treatment demands elimination of these toxic products, and this may be done by the radiant light bath, or the Turkish bath. Electro-therapeutics applied by an operator who understands the therapeutic actions set up in the tissues, the selection of the best means for this purpose, and who has the technical knowledge to apply them are of great value. The writer has employed galvanic and faradic, static and "high-frequency currents with success.—*Medical Record*, January 18 1908.

POST HEMORRHAGIC ANEMIC.

The anemia which follows the hemorrhages of trauma, gastric or intestinal ulcers, severe epistaxis, child birth, profuse menstruation or hemorrhoids presents a clinical picture that is so well-known that it requires no description.

Examination of the blood immediately after a severe hemorrhage usually shows no apparent change in its number of corpuscles, for the portion lost withdrew the blood as a whole, and the portion remaining in the body, while decreased in volume, will be found to contain a normal ratio of the fluid and cells. Shortly after a hemorrhage, however, the tissues of the body give up large quantities of fluid to restore the necessary volume of the blood and a condition of true hydremia ensues. Examination of the blood three or four hours after a severe hemorrhage, therefore, shows a very marked oligocythemia. Reconstruction must now take place and the response to the bodily demand is sometimes remarkably prompt, but in most instances it is a hard up-hill fight. This is to be expected, for the disproportion between the cells and the fluid elements of the blood, and the essential depression of all vital functions, makes recuperation a difficult process at best.

Much can be done, however, to assist the body in its efforts to restore normal conditions. The first and most essential requirement is absolute rest in a prone position. In some instances, it may be necessary for a few days to have the couch or bed tilted so that the patient's head shall be lower than the feet. Sudden movements or a sudden rising to an upright posture must be strictly interdicted as these are always liable to produce a fatal syncope. Following severe hemorrhage, the blood pressure is always lowered, and even if a certain degree of tension is apparently restored, it is very unstable, and may be lost instantly with all of the resulting dangers on the heart and central nervous system.

Another precaution to be taken is to frequently change the patient's posture from one side to the other. The hydremic state of the blood, and the loss of blood tension predisposes to gravitation œdema in the lungs and other organs, and the simple procedure of changing the patient's position often avoids annoying and serious complications.

Considerable quantities of water are always necessary after hemorrhage, but it should never be given in large amounts at any one

time. Two or three tablespoonsful at a time by the mouth every few minutes is much more beneficial than to allow a patient to drink to satiation. Excessive thirst is always soon controlled by small enemas (one pint) of saline solution, as warm as can be borne, repeated every three or four hours. These also serve admirably to very materially raise arterial tension. It is no uncommon thing to observe complete anuria for even twenty-four hours after severe hemorrhages, but the warm saline enemas soon correct this condition.

Feeding is one of the most important details in post-hemorrhagic treatment. Liquid food should be used in preference to solids for obvious reasons, and may consist of milk, beef extracts, white of egg, etc. Small quantities should be given at short intervals, as it must be remembered that the digestive function is always more or less depressed and can only do a portion of its usual work. A good reliable hematic is early necessary, one that can materially hasten hematosi without endangering the digestive and assimilative functions in any way, shape, or fashion. Pepto-Mangan (Gude) is one of the most dependable remedies of this class and its hematopoietic properties are well-known. Under its use the cellular elements of the blood are rapidly increased, and the whole physical condition is greatly improved. The various organs resume their functions and the distressing and dangerous effects of hemorrhage are safely and properly overcome.

CHANTEMESSE'S OPHTHALMO-REACTION IN TYPHOID FEVER.

Once more we are to see a so-called decisive, pathognomonic sign for typhoid fever go to the wall, and again witness the discomfiting, although not unfamiliar, spectacle of a medical investigator in confusion. As is the rule, the inordinate desire to rush into print with medical novelties, long ere they have had the beneficent seasoning of second thought, is doubtless the undoing of this hasty thesis by Chantemesse. In July of this year, that author reported to the Paris Academy of Medicine that a few drops of typhoid toxins instilled upon the conjunctiva of the lower lid caused a redness and secretion, which reaction he deemed a positive sign of typhoid fever. Still more recently Kraus, Lusenberger and Russ have published a series of results obtained by conjunctival instillation of typhoid toxins prepared according to the method of Chante-

messe. In twenty-two typhoid patients, with a positive Widal, they noted a typical reaction in all, within six hours, thus corroborating the work of Chantemesse. On the other hand in twenty-two patients suffering from various diseases, including pneumonia, multiple sclerosis and tuberculosis, the reaction was observed in 50 per cent. of the cases. That this particular reaction is not peculiar to the typhoid toxins is witnessed by the fact that diluted tuberculin when instilled upon the conjunctiva of twelve typhoid patients produced the typical reaction of redness and secretion in eleven of the cases at the end of eighteen hours. The fact that Chantemesse might, just as well as not, have made these control-tests himself, all the more emphasizes the shortcoming. In general, such research is, at best, disconcerting; although, in the tolerant spirit of the day, it should not be altogether decried, since oftentimes even faulty work has its suggestive value.—*N. Y. State Med. Jour.*

ARMY MEDICAL CORPS EXAMINATION.

Preliminary examinations for appointment of assistant surgeons in the army will be held on May 4th and August 3, 1908, at points to be hereafter designated.

Full information concerning the examination can be procured upon application to the Surgeon General, U. S. Army, Washington, D. C. The essential requirements to securing an invitation are that the applicant shall be a citizen of the United States, shall be between twenty-two and thirty years of age, a graduate of a medical school legally authorized to confer the degree of doctor of medicine, shall be of good moral character and habits, and shall have had at least one year's hospital training or its equivalent in practice. The examinations will be held concurrently throughout the country at points where boards can be convened. Due consideration will be given to the localities from which applications are received, in order to lessen the traveling expenses of applicants as much as possible.

Applicants holding diplomas from reputable literary or scientific colleges, normal schools or high schools, or graduates of medical schools which require an entrance examination satisfactory to the faculty of the army medical school, will not be examined in subjects of general preliminary education,

In order to perfect all necessary arrangements for the examinations of May 4th, applications must be complete and in possession of the Surgeon General on or before April 1st. Early attention is therefore enjoined upon all intending applicants.

There are at present twenty-three vacancies in the medical corps of the army.

CUTANEOUS TUBERCULIN VACCINATION IN THE DIAGNOSIS OF TUBERCULOSIS.

William J. Butler of Chicago describes the technique of tuberculosis vaccination by the skin as a means of diagnosis. Its action is similar to that of vaccine against smallpox. A positive reaction consists of a papule, at first bright red, later dusky red with a slight areola appearing in twenty-four hours after vaccination with tuberculin. Small vesicles may appear at the site, which soon fade and leave slight pigmentation. There are no constitutional symptoms. The test acts best in children since healthy adults may give the reaction. It also fails in the last days of life in fatal tuberculosis. A positive reaction in a child is diagnostic of tuberculosis, and failure of the reaction does not prove absence of tuberculosis.—*Medical Record*, February 1, 1908.

CONGENITAL IRIDEREMIA WITH CATARACT.

Edgar S. Thompson of New York describes an interesting case of congenital irideremia combined with cataract in both eyes, in a man of thirty-six years, in robust health. Treatment for the cataracts gave some improvement of vision.—*Medical Record*, February 1, 1908.

WHY NOT?

An Alabama man, meeting an old darky formerly in his service, put to him the usual question:

"Well, Jed, how are you to-day?"

"Tol'able, sah, tol'able!" cautiously replied Jed. "Ah'd be all right, sah, if it wa' n't for de rheumatism in mah right laig."

"Ah, well, Jed, we mustn't complain," said the questioner. "We're all getting old, and old age does not come alone."

"Old age, sah!" was the indignant protestation of Jed. "Old age ain't got nuthin' to do wid it, sah. Heah's mah other laig jest as o'd, an' dat's sound an' soople as kin be!"—*February Lippincott's*,